Botswana

Country Operational Plan 2019

Strategic Direction Summary

May 10, 2019

Table of Contents

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1.0 Goal Statement

Botswana, once a world leader in the response to HIV, now faces unique structural impediments to its progress in reaching HIV epidemic control. Formal and informal policies hinder efforts to diagnose and immediately treat people living with HIV. Although immediate and universal ART provision has been adopted in Botswana, providers and clients remain reluctant to embrace same-day linkage to treatment efforts, and some populations are still left behind. Access to free government treatment remains unavailable to the estimated 30,000 people living with HIV in Botswana who are non-citizens. Current programs have also seemingly left men behind – there are an estimated 20,000 HIV-positive men who are undiagnosed, and another 50,000 who are either not virally suppressed or who know their status but are not on ART. Evidence suggests a need for a major shift in the current policy environment and program implementation in order for Botswana to realize its potential for stemming the national HIV epidemic.

The goal of COP19 is to work as "one Botswana" with all stakeholders to eliminate policy barriers and re-focus strategies on delivering innovative, client-centered programs in order to reach the 95-95-95 goals across all sex and age bands. The Government of Botswana has realized the need to do things differently and has recently adopted the recommended Minimum Program Requirements (MPRs). Among the MPRs that will help revitalize the response to HIV at the ground level are the offer of same-day and fast track ART initiation to all newly diagnosed patients; adoption of differentiated service delivery models, including three months of ART delivery (MMD) for stable patients; better screening and more effective case identification strategies, including scale-up of self-testing and index testing with active partner notification; the re-introduction of TB Preventative Therapy (TPT) across the country; the transition to TLD and removal of Nevarapine-based drug regimens; and improving patient-level data collection and integration of data systems. The Minister of Health and Wellness has assured the U.S. Ambassador that his ministry is taking seriously its commitment to implement all MPRs, and he has raised the issue of providing free HIV treatment to non-citizens to Botswana's Cabinet for approval. The Office of the Global AIDS Coordinator (S/GAC) has approved conditional catalytic funding to MoHW to support treatment for non-citizens following Parliament's approval of the policy change and pledge of future budget support.

In COP19, PEPFAR/B will support the GoB to ensure implementation of the MPRs with fidelity at all districts and sites while building on new data available to adjust approaches and address key barriers. A site realignment focused on 71 high volume facilities, and several key population hotspots, is intended to enable PEPFAR and the GoB to demonstrate the impact of fully implementing the MPRs nationwide with fidelity in the highest disease burdened areas. Earlier this year, Botswana launched the Botswana AIDS Impact and TB Prevalence Survey (BAIS V) with results expected at the end of 2019. COP19's realignment to a national direct support program to achieve policy implementation and ensure quality HIV service delivery should position Botswana to move quickly towards 95-95-95 once BAIS V data becomes available. Meanwhile, programming to reach key populations is being improved with data from the second Botswana Behavioral and Biological Surveillance Survey (BBSS 2017) which provided updated KP population estimates and highlighted some successes of the PEPFAR-supported KP program to date, such as a decrease in prevalence for female sex workers from 61.9% to 42.8% between 2012 and 2017.

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COP19 will also replicate at scale relevant lessons learned from "reboot" of COP18 implementation. Botswana has embraced the term reboot, which can mean to start anew or transform, by bringing HIV/AIDS providers and service delivery stakeholders onboard to ensure every HIV-diagnosed individual is immediately linked to treatment, retained in care and remains virally suppressed. Focus at the ground level will include improvements in:

- **Optimization of HIV Case Identification**: This includes improved screening techniques, offering services at multiple service points and, where feasible, after hours and on weekends. Evidence has shown higher yields among men during extended hours.

- **Same-Day and Fast-Track Initiation of ART**: Clients who test HIV positive will be escorted to a nurse prescriber or physician for same-day ART initiation. In cases where initiation within three days is not possible, facilities will refer clients to community partners to ensure ART initiation occurs within one week of diagnosis.

- **Optimization of Viral Load Access**: All government and private practices must devise systems for ensuring each and every client on ART receives at least one viral load test per year, and receives those results. Providers must track clients who miss their viral load appointments or results in their medical files and ensure they are linked back to receive them. Tracking efforts will include engaging community partners to ensure clients are linked for viral load.

- **Patient Retention in Treatment:** All HIV service providers must devise strategies for retaining clients on ART, creating and instituting systems for monitoring missed appointments and taking action before clients get lost to care. Providers track defaulters and devise case-management plans to bring them back into treatment. Defaulters are referred to community partners for follow up and re-initiation.

- **M&E:** Reporting results of case identification, ART initiation, retention and viral load tests in electronic patient management systems is just as important to the success of the national response as the work itself. Without good data in electronic systems and shared in the national data warehouse, Botswana cannot reliably show success at attaining the 95-95-95 goals.

Reboot activities have been taking place with great success since February 2019 at 41 high-volume government facilities, two non-governmental wellness clinics and surrounding communities and five KP hotspots. In these places, case identification and yield has improved, linkage-to-treatment rates are increasing, and retention and viral load coverage is greatly improved. In COP19, it is expected that DHMTs take the coordinating role for Reboot activities in their respective districts, working closely with PEPFAR, implementing partners and all district stakeholders to identify challenges and come up with district and site-specific solutions.

PEPFAR/B will continue prevention efforts through the VMMC, OVC, Cervical Cancer and DREAMS programs. VMMC will strive to close the unmet need following the gap analysis conducted in COP18 with the MoHW. The OVC will increase its focus on the 9-14 year olds girls and boys working through schools to provide primary prevention of sexual violence and HIV and other socio-economic interventions.

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Through DREAMS, PEPFAR/B is offering a package of evidence based combination prevention interventions that target vulnerable adolescent girls and young women (AGYW), their families, communities and sex partners with the ultimate goal of protecting the AGYW from HIV infection. In COP19, PEPFAR/B will continue to build on the existing platform and strategies to increase cervical cancer screening among Women Living with HIV (WLHIV) aged 25-49 on ART.

COP19 will require a coordinated effort from all stakeholders. Failure to address barriers could mean the further loss of international funding for Botswana. But worse than that, failure would mean fewer people on treatment and virally suppressed, and consequently more new infections and lost lives. Botswana should be, as it once was, a world leader in the response to HIV. COP19 is the opportunity for the country to return to the front of the race for an AIDS-free generation.

2.0 Epidemic, Response, and Program Context Statement

2.1 Summary statistics, disease burden and country profile

Botswana is a sparsely populated land locked country with a population of approximately 2.36 million (Census 2018 Projection). HIV infection in Botswana, one of the hardest hit countries in the world, is largely concentrated in the urban and peri-urban areas of the country with the highest disease burdens in Greater Gaborone and Greater Francistown. The burden in absolute numbers is highest among older populations (age 25+), and strikingly so among women. Botswana's 2017 GNI per capita, according to World Bank, was $6,730. While classified as an upper middle-income country, its Gini index was 53.3 (World Bank, 2015), reflecting one of the starkest income disparities globally.

The most recent Botswana prevalence survey was conducted in 2013. However, in April 2019, Botswana launched the Botswana AIDS Impact (BAIS V) and TB Prevalence Survey. Until the preliminary results are shared and the final report, expected at the end of 2019, PEPFAR/B will continue to use program data and UNAIDS Spectrum estimates to guide program decisions. The most recent UNAIDS Spectrum (2018) estimates suggest a lower burden of HIV compared to the previous year, although modifications to the model may account for the apparent differences. The PLHIV estimate is now 369,707, which is a reduction by approximately 2.24% from the prior year's Spectrum estimate of 378,184. The estimated incidence rate decreased from 0.58 last year to 0.44, and estimated new infections decreased from 13,797 to 8,517. UNAIDS' estimates of Botswana's HIV prevalence have decreased from 17% to 16%. Males age 15-24 and both females and males older than 25 appear to have a lower estimated prevalence in the 2018 estimates compared to the 2017 estimates. The number of pregnant women estimated to need ARV has increased from 11,629 to 12,520 as the estimated population size and number of annual births have increased. Other areas of note comparing 2017 and 2018 include:

- Increase in AIDS-related deaths from 4,062 to 4,923 (highest in 25+ males and females);
- Decrease in estimated AGYW population from 230,284 to 212,909.

The second Botswana Behavioral and Biological Surveillance Survey (BBSS 2017), the first in five years, has provided data related to key populations (KP). The data analysis shows significant progress in reaching KP, especially female sex workers (FSWs). The results show a decrease in prevalence for FSW from 61.9% to

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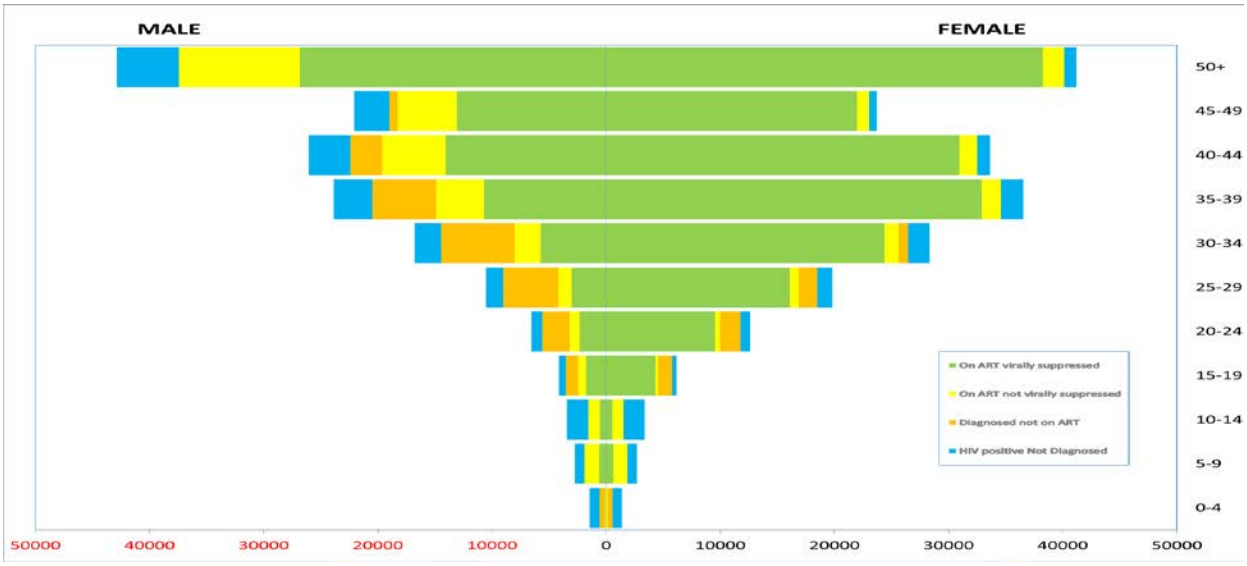
42.8% (2012, BBSS; 2017 BBSS). For men who have sex with men (MSM) the trend was not the same, with prevalence increasing from 13.1% in 2012 to 14.8% in 2017. The report is important to understand the epidemic in KP and allows us to further focus our KP activities.

Figure 2.1 and Table 2.1.1 reflect a national ART coverage estimate of 82%. Women age 25+ have the highest coverage at 94%; the lowest ART coverage is among males younger than 15 and males 15-24 years, 47% and 53%, respectively. Botswana's viral suppression rate overall is high at 85%, however younger people have much lower rates, with the < 15 years olds at 34%. The PEPFAR/B team used PEPFAR program data and the Data Warehouse to evaluate testing yields and linkage to ART rates.

Figure 2.1 Botswana: PLHIV Population Pyramid



In FY18, approximately 403,657 people were tested, about 16,320 were identified as HIV positive and a little more than 12,100 initiated ART. The overall testing yield was 4%, while the overall ART initiation rate was 74.5%. These data are invaluable for assisting the national and PEPFAR programs in developing population specific programming approaches.

The Botswana PMTCT program continues to achieve high coverage of HIV testing and enrollment of HIV-infected pregnant women on life-long ART. National HIV testing uptake of 97% and treatment uptake of 96.2% have resulted in a perinatal transmission rate of 0.7% in 2018 (national PMTCT program data). PEPFAR/B's overall FY18 achievement for the percentage of pregnant women with known HIV status at antenatal care was 95.9% (22,999/23,992) and the overall achievement for PMTCT_ART was 94.5% (5139/5440). In FY19 Q2, the achievement for women who knew their HIV status was 99.9% (6451/6460), an improvement from 99.7 % (5785/5802) in FY19 Q1 and the achievement of pregnant women who registered at Antenatal Care (ANC) who received lifelong ART in FY19 Q2 was 99.9% (1479/1480) compared to 99.8% in the FY19 Q1. Despite high coverage of HIV testing and enrolling HIV-infected pregnant women on life-long ART, coverage for early infant diagnosis (EID) at 4-6 weeks remained low at 56% according to 2018 national program data. This trend had never surpassed 50% since the inception of the EID program until FY17 data showed 60% EID coverage at two months and 88% at 12 months. EID continues to be a major area of focus for PEPFAR/B in FY19 and FY20.

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Table 2.1.1 90-90-90 cascade: HIV diagnosis, treatment and viral suppression

90-90-90 cascade: HIV diagnosis, treatment and viral suppression*										
Epidemiologic Data					HIV Treatment and Viral Suppression			HIV Testing and Linkage to ART Within the Last Year		
	Total Population Size Estimate 1	HIV Prevalence 2	Estimated Total PLHIV 2	PLHIV diagnosed	On ART 2	ART Coverage 2	Viral Suppression 2	Tested for HIV 3	Diagnosed HIV Positive 3	Initiated on ART 3
	(#)	(%)	(#)	(#)	(#)	(%)	(%)	(#)	(#)	(#)
Total population	2,356,014	15.69%	369,707	326,188	302,403	82%	85%	403,657	16,320	*12,105*
Population <15 years	721,736	2.09%	15,059	6,342	7,033	47%	34%	5,265	57	*101*
Men 15-24 years	215,729	4.93%	10,627	9,134	5,655	53%	72%	47,799	758	*356*
Men 25+ years	605,260	23.46%	142,019	122,068	102,365	72%	72%	117,892	6081	*4,471*
Women 15-24 years	212,909	8.83%	18,790	17,547	14,586	78%	95%	91,223	4194	*1,506*
Women 25+ years	600,380	30.52%	183,212	171,097	172,764	94%	95%	141,478	7056	*5,671*
MSM [4]	16,443	14.80%	3,141	65	44	73.5%	n/a	948	50	*23*
FSW [4]	17,015	42.80%	7,282	1,599	1,101	87.6%	n/a	2,731	301	*179*
PWID	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Priority Pop (Partners of FSW)	2,597	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Priority Pop (Children of FSW)	477	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a

Sources/Key

NA = Not Available
1 Census 2018 Projections
2 UNAIDS 2018
3 APR 2018 (PEPFAR supported sites)

Since inception of the national safe male circumcision (SMC) program, 225,732 voluntary medical male circumcision (VMMC) procedures were performed in Botswana, representing approximately 35% coverage in the male populations aged 10 to 49 years. VMMC will continue to be a major area of focus for PEPFAR/B during COP 2019 implementation, as we strive to close the unmet need following the gap analysis conducted with the MoHW in COP18**.**

Botswana conducted the BBSS II (2017) among KP in five districts (Gaborone, Francistown, Chobe, Palapye, and Ngamiland South). Among FSW, 96% had been tested for HIV at some point in the past, and about half were tested in the last year. Also, access to treatment for those FSW who knew their status improved drastically since 2012 – from 25% to 88%, and 99% report taking their ARVs every day. The proportion of MSM who have ever tested has increased significantly since 2012 (76% vs. 92%) and this trend is seen across districts. Testing rates are highest in Gaborone and Chobe and fairly similar in Francistown, Palapye and Maun. Most have been tested in the last 12 months. In COP19, PEPFAR/B will continue to focus on keeping KP negative through prevention efforts that include PrEP, condoms and lubricants as well as addressing proximate determinants of HIV and STI infection, scaling up self-testing and index testing strategies and a continued increased focus on enhanced linkage to and retention in care.

The key intervention area for the key population program in COP19 will target keeping the young key population members negative through PrEP provision, and condom and lubricant distribution. Proximate determinants of HIV and STI infection will be addressed during the HIV prevention sessions. Additionally, the KP program will focus on scaling up self-testing and index testing strategies that use social networks, enhanced peer outreach approaches and social media approaches. For the second 90, PEPFAR/B will focus on enhancing our linkage to care and early initiation on ART using a differentiated model of services. Finally, for the third 90, PEPFAR/B will scale up with fidelity activities that retain those who are on treatment, provide adherence support, and ensure that they are virally suppressed.

The biggest development in COP19 is the recent adoption, by the GoB, of the WHO normative guidance and PEPFAR Minimum Program Requirements (MPRs) and the development of a Botswana-specific MPR related to national data. These overarching MPRs encompass the critical elements necessary to achieve epidemic control, and have set the stage for how MoHW and PEPFAR/B will collaborate now and in the future.

These 14 Minimum Requirements comprise of:

1. Adoption and implementation of Test and Start with demonstrable access across all age, sex, and risk groups.
    - In line with the WHO recommendations, all PEPFAR supported countries should offer same-day initiation of ART to all newly diagnosed HIV patients with no contraindications to rapid or same- day ART initiation independent of place of diagnosis. Accordingly, Botswana should scale up the initiation of ART within 7 days for at least 90% of all persons newly diagnosed with HIV infection, including non-citizens, by the end of COP19.

2. Adoption and implementation of differentiated service delivery (DSD) models, including six month multi-month scripting (MMS) and delivery models to improve identification and ARV coverage of men and adolescents.
    - The team should implement DSD approaches in all sites that include, by the end of the year, a minimum of 6-month ART delivery for stable patients, as well as other strategies to ensure ART coverage and utilization by men and persons 25 or younger.
3. Completion of TLD transition, including consideration for women of childbearing potential and adolescents, and removal of Nevirapine based regimens.
    - Botswana will exhaust the remaining TLE stock and complete its TLD transition in COP19.
4. Scale up of index testing and self-testing, and enhanced pediatric and adolescent case finding, ensuring consent procedures and confidentiality are protected and monitoring of intimate partner violence (IPV) is established.
    - The team should work with key partners to advance policy shifts permitting index partner testing with fidelity as defined by PEPFAR guidance and Solutions Platform resources.
5. TB preventive treatment (TPT) for all PLHIVs must be scaled-up as an integral and routine part of the HIV clinical care package.
    - The team must work with its GoB partners to expand eligibility for TPT beyond those for whom it is approved (< 5 yr olds). TPT must become a routine part of clinical care.
6. Direct and immediate (>95%) linkage of clients from testing to treatment across age, sex, and risk groups.
    - Team should scale up same-day ART initiation. COP19 IP work plans need to be revised accordingly.
7. Elimination of all formal and informal user fees in the public sector for access to all direct HIV services and related services, such as ANC and TB services, affecting access to HIV testing and treatment and prevention.
    - No user fees are collected at public facilities for HIV and related services.
8. Completion of VL/EID optimization activities and ongoing monitoring to ensure reductions in morbidity and mortality across age, sex, and risk groups.
    - Team must address and resolve policy barriers to achieve viral load monitoring for all persons on ART.
9. Monitoring and reporting of morbidity and mortality outcomes including infectious and non-infectious morbidity.
    - Data systems must be updated to collect morbidity and mortality data (TX_ML) and providers should be trained to report it consistently.
10. Alignment of OVC packages of services and enrollment to provide comprehensive prevention and treatment services to OVC ages 0-17, with particular focus on adolescent girls in high HIV-burden areas, 9-14 year-old girls and boys in regard to primary prevention of sexual violence and HIV, and children and adolescents living with HIV who require socioeconomic support, including integrated case management.
    - PEPFAR/B must update its data systems to track the layering of DREAMS services.
11. Evidence of resource commitments by host governments with year after year increases.

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- GoB remains the majority proportion of the national HIV response. However, it must extend treatment access to non-citizens, who are estimated to account for 7% of PLHIV in Botswana.

12. Clear evidence of agency progress toward local, indigenous partner prime funding.
    - Each agency should work with their headquarters team to allocate at least 70% of resources to local/indigenous partners in COP19 and work toward a timeline for progress in future FYs.
13. Scale up of unique identifier for patients across all sites.
    - PEPFAR/B should utilize its unique patient identifier to improve tracking of patients, particularly those who have fallen out of care, passed away, or relocated.
14. Develop and implement an M&E strategy to track and improve performance across the health sector.

(A more detailed description of these 14 MPRs and how they are being addressed and supported can be found in section 4.3 and Appendix D)

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Table 2.1.2 Host Country Government Results

Host Country Government Results															
	Total		<15				15-24				25+				*Source, Year*
			Female		Male		Female		Male		Female		Male		
	N	%	N	%	N	%	N	%	N	%	N	%	N	%	
Total Population	2,356,014	100	357,581	15.2%	364,155	15.5%	212,909	9.0%	215,729	*9.2%*	600,380	25.5%	605,260	25.7%	Census 2018 Projections
HIV Prevalence (%)		16%		2%		2%		9%		5%		31%		24%	UNAIDS, 2018
AIDS Deaths (per year)	4,923		269		276		302		245		1,838		1,993		UNAIDS, 2018
# PLHIV	369,707		7,450		7,609		18,790		10,627		183,212		142,019		UNAIDS, 2018
Incidence Rate (Yr)		0.44		0.063		0.063		0.99		0.41		0.59		0.61	UNAIDS, 2018
New Infections (Yr)	8,517														UNAIDS, 2018
Annual births	54,546	97%													PMTCT, FY2018
% of Pregnant Women with at least one ANC visit	46,872	94%	222	5%			20,317	43%			26,333	56%			BFHS, 2007
Pregnant women needing ARVs	12,520	22%													PMTCT, FY2018
Orphans (maternal, paternal, double)	123,459		51,284		52,226		10,044		9,906		NA		NA		BAIS IV, 2013 Census 2018 Projection
Notified TB cases (Yr)	5,260		156	3%	146	3%	390	7%	343	7%	1718	33%	2507	48%	BNTP, 2016
% of TB cases that are HIV infected	2,946	56	21	0.7	30	1	135	4.6	72	2.5	1,224	41.6	1,463	49.7	BNTP, 2016

% of Males Circumcised	318,752	27%			130,688	41%			126,545	39,7%			61,838	19,4%	BAIS IV,2013 Census 2018 Projections
Estimated Population Size of MSM	16,443														National mapping and BBSSII, 2017
MSM HIV Prevalence**		14.80%													National mapping and BBSSII, 2017
Estimated Population Size of FSW	17,015														National mapping and BBSSII, 2017
FSW HIV Prevalence***		42.80%		14.70%				34.80%				79.20%			National mapping and BBSSII, 2017
Estimated Population Size of PWID	NA	NA													
PWID HIV Prevalence	NA	NA													
Estimated Size of Priority Populations (AGYW)	570,490	24%	357,581	49.50%			212,909	49.7%							Census 2018 Projections
	If presenting size estimate data would compromise the safety of this population, please do not enter it in this table.* * MSM prevalence within the five sites analyzed in BBSSII is 14.80%; the 2017 study revealed the prevalence rate in the original three BBSS sites to be 19.1%, a significant increase from the 2012 results* ****Age groups for FSW prevalence is as follows: <20, 20-29, and 40-49*														

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Figure 2.1.3 National and PEPFAR Trend for Individuals currently on Treatment

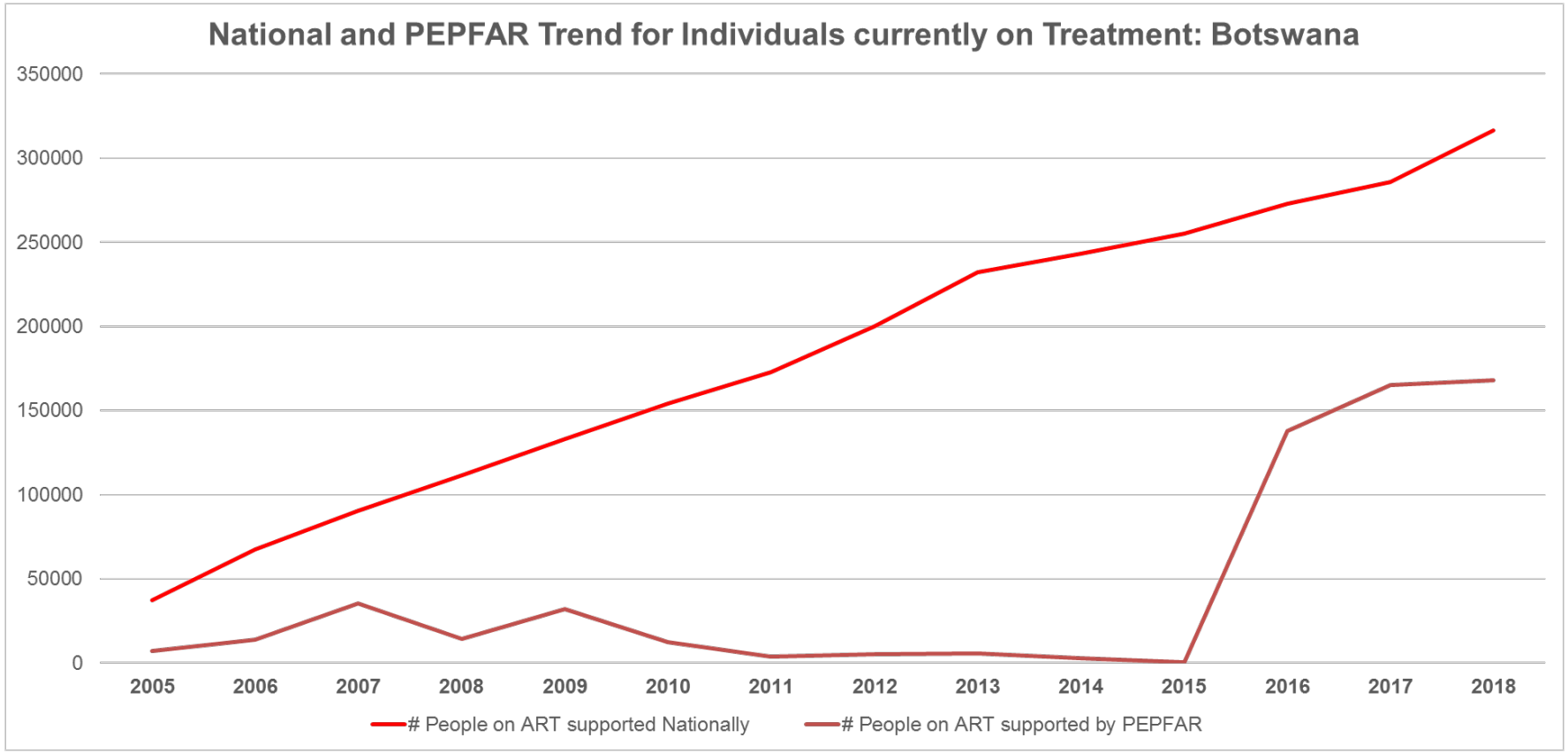

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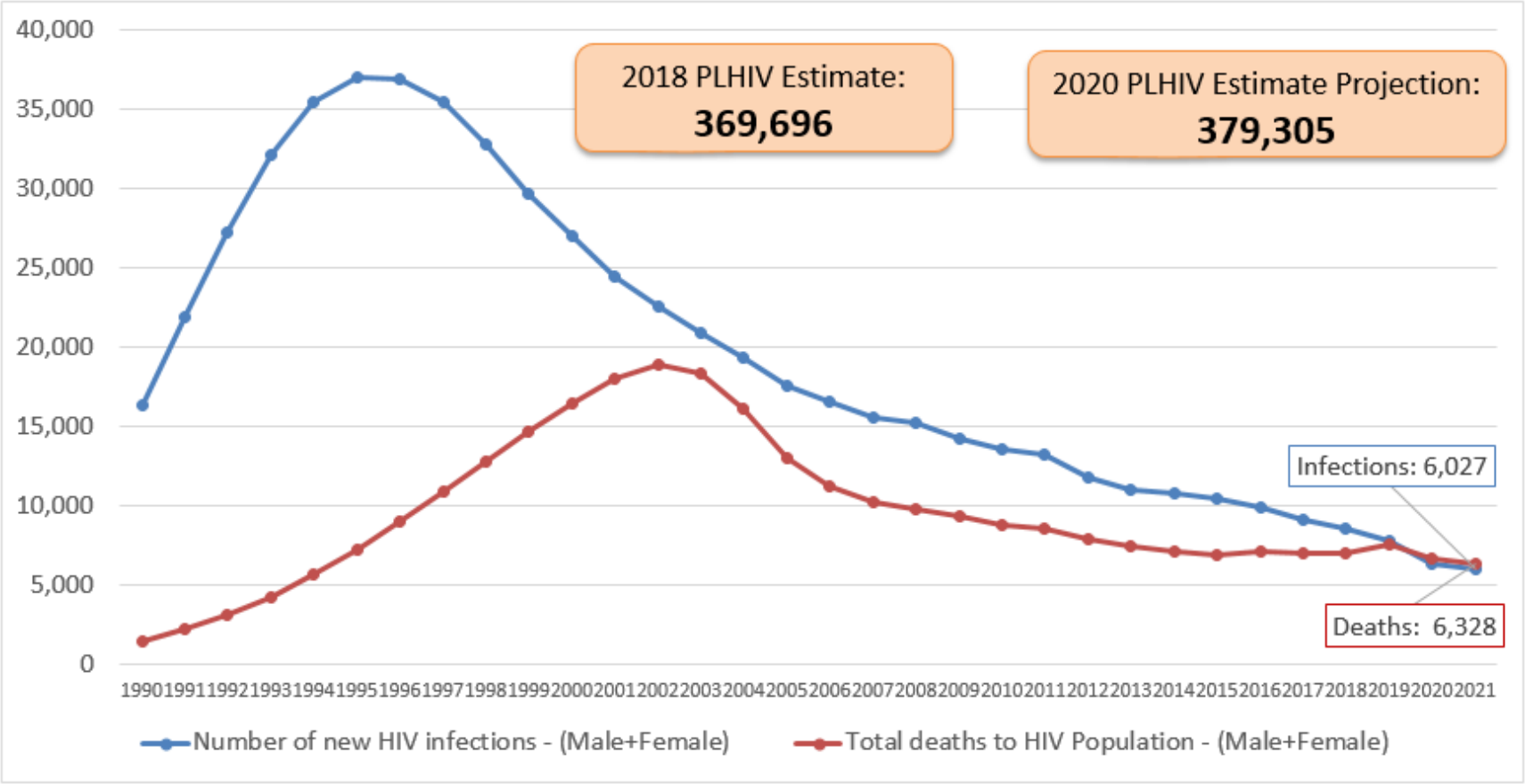
Figure 2.1.4 Trend of New Infections and All-Cause Mortality among PLHIV



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2.2 Investment Profile

A major constraint of the Botswana public health system is efficiency and effectiveness of spending, not availability of funding. Botswana's fiscal space is relatively unconstrained in absolute terms, in the short-term, due to high fiscal revenues from diamond exports and a history of prudent public financial management. Despite a positive outlook in the short-term, a steady, long-term contraction of fiscal space is taking place as the fiscal contribution of the highly-taxed diamond sector diminishes. In this context, the high level of public spending commitments, much of which involves very inefficient spending generated on the basis of high historical revenues, has to be managed downwards while ensuring that public resources are allocated as optimally as possible in improving social welfare. Major health financing reforms are needed to improve efficiency and address financial sustainability issues.

Economic growth is volatile and still highly subject to the performance of the diamond sector, which in relative terms is in long-term decline. Although renowned as one of the world's fastest-growing economies in the past, this has not been the case for many years. The average real GDP growth rates in the first 25 years after independence were consistently in double figures, as diamond mining expanded. But over the past 25 years, real GDP growth rates have been unspectacular, averaging 4% a year, which has been inadequate to create sufficient jobs for the growing labor force. Botswana therefore faces major long-term challenges of generating new sources of export-led growth, to supplement and eventually replace diamonds.

Botswana consistently conducted National AIDS Spending Assessments (NASA) every three years, from 2003-2012, to track and report on HIV/AIDS spending. Howvever, Botswana's last NASA was done in 2012 and National Health Accounts in 2013/14. NASA reports for the years 2006-2012, an estimated 66% of the national response was financed by the GoB, 32% by international partners and 2% by domestic private sources. Botswana MoHW is in the process of developing National Health Accounts for 2014/2015, 2015/16, 2016/2017 and 2017/18; data collection is ongoing and a final report is expected by June 2019.

The GoB, the World Bank and UNAIDS jointly commissioned the HIV/AIDS Investment Analysis for a rapid tracking and analysis of HIV/AIDS investment in Botswana from 2012/13 to 2017/18. In USD terms, an estimated $964,000,000 was spent on HIV/AIDS over the six year period from 2012 to 2018. Annual spending data however shows a downward trend from $183,000,000 in 2012/13 to $154,000,000 by 2017/18 (Reference Figure 2.2.1).

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Figure 2.2.1 Botswana Annual HIV/AIDS Spending in USD 2012/13-2017/18

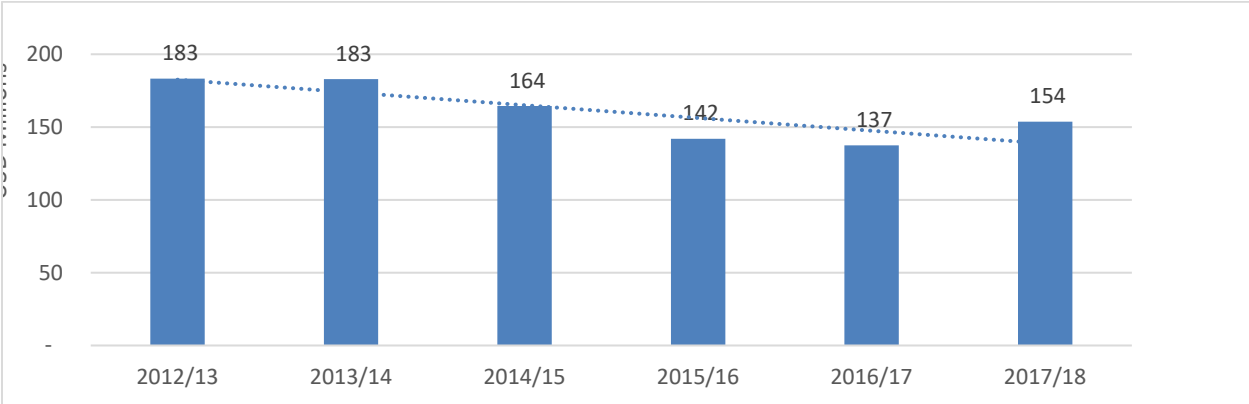

Table 2.2.1 Spending by Financing Sources (USD)

	GoB	PEPFAR	GF	Merck Company Foundation	Total
2012/13	78,387,985	46,777,240	-	3,646,389	128,811,614
2013/14	88,432,012	42,079,121	-	14,312,904	144,824,037
2014/15	89,085,339	38,887,826	-	10,155,192	138,128,358
2015/16	95,661,728	41,163,022	-	1,345,525	138,170,275
2016/17	84,922,733	47,585,866	3,814,522	-	136,323,121
2017/18	91,760,970	43,498,510	9,775,993	-	145,035,473
Total	528,250,768	259,991,585	13,590,514	29,460,010	831,292,878

Table 2.2.1 shows the spending on HIV/AIDS by financing sources from 2012/13 to 2017/18. Botswana's spending on HIV/AIDS has remained fairly constant over the 6-year period of 2012/13 to 2017/18. Over the six-year period, the government of Botswana contributed 64%, PEPFAR 31%, Merck Company Foundation 3% and The Global Fund 2% of all spending on HIV/AIDS. The Merck Company Foundation ceased its funding of the national response during the 2015/16 financial year with The Global Fund resuming its funding of the national response in the following four years of 2016/17, after years of absence. From 2012/13 to 2017/18, $428,595,860 (52%) was spent on treatment, care and support, $190,107,470 (23%) was spent on social protection, $95,376,890 (11%) was spent on prevention,

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excluding PMTCT which consumed 3% of financial resources, and $78,572,830 (9%) was spent on governance and sustainability. The rest of the remaining programs make up 1% of the overall budget.

Spending by GoB and PEPFAR has remained fairly consistent over the six-year period, in line with the overall spending on HIV/AIDS. GoB spending peaked at just over $90 million in 2015/16. This was due to increased procurement of ART related pharmaceutical products in preparation for the Treat All program, which commenced in June 2016. The consistent year on year spending by PEPFAR, which averages about $50.4 million (P470 million) per year, masks the fact that funding allocations to Botswana were decreasing over this period from $75.9 million in 2012/13 to $38.3 million in 2016/17. The consistency of the spending is due to prior periods of COP allocations being carried over from year to year. There is an interesting relationship between spending by GoB and PEPFAR. GoB spending increases in the years of decreasing PEPFAR spending and decreases when PEPFAR spending increases.

Table 2.2.2 shows analyses of the HIV/AIDS expenditure in Botswana for 2017/18 using the program areas or spending categories of the Global AIDS Monitoring (GAM) matrix. The GoB remains the primary funder of HIV/AIDS programs contributing 63% of the funds used to address the epidemic, followed by PEPFAR at 30% and GF at 7%. More than 60% of all available funds were spent on treatment, care and support, 17.3% on social protection, and 10.8% on governance and sustainability. Prevention activities received fewer than 10% of the entire funding. Prevention spending seems to be decreasing over the years. With increased new infections, opportunities must be sought to fund more evidence-based and context relevant prevention interventions. Except for Governance and sustainability, GoB was the major source of funding for all program areas. The GoB contributed more than 80% of the funds used for several program areas, including Prevention of vertical transmission of HIV, Gender programs, Social protection, Community mobilization, and other essential activities outside the suggested framework of core HIV & AIDS programs.

Table 2.2.2 Analyses of the HIV/AIDS expenditure in Botswana for 2017/18

Unclassified

Program Area	Total Expenditure (USD)	PEPFAR (%)	GF (%)	Host country (%)
Treatment, care and support	87,910,775	32	1	68
Prevention of vertical transmission of HIV	3,341,807	13	-	87
Prevention	9,790,892	38	48	15
Gender programs	149,703	-	-	100
Programs for children and adolescents	1,065,909	-	91	9
Social protection	25,145,609	15	-	85
Community mobilization	452,417	-	-	100
Governance and sustainability	15,603,149	50	16	34
Critical enablers	799,031	-	93	7
TB / HIV co-infection, diagnosis and treatment	201,605	-	100	-
Other essential programs outside the suggested framework of core HIV & AIDS programs	574,641	-	-	100
Total	145,035,539	30	7	63

Table 2.2.3 Annual Procurement Profile for Key Commodities

Annual Procurement Profile for Key Commodities					
Commodity Category	Total Expenditure (USD)	% PEPFAR	% GF	% Host Country	% Other
ARVs	48,988,813	13	0	87	0
Rapid test kits	1,228,130	24	0	76	0
Other drugs	49,836,563	0	0	100	0
Lab reagents	5,073,002	0	0	100	0
Condoms	1,868,316	-	-	100	-
Viral Load commodities	12,802,257	-	-	100	-
VMMC kits	33,640	-	-	100	-
MAT	-	-	-	-	-
Other commodities	-	-	-	-	-
Total	119,830,722	5.46	0	94.54	0

The expenditure figures were converted from the local currency (Botswana Pula – BWP) using exchange rate of 10.8307 from OANDA Currency converter on April 4, 2019; www.oanda.com/currency/converter

During the GoB Fiscal Year 18/19 (April 1, 2018 to March 31, 2019), as shown in Table 2.2.3, with data obtained from the Central Medial Stores (CMS), the procurement of key health commodities has primarily been funded by GoB (94.54%), with a limited supplement from PEPFAR. Global Fund and other donors made no contributions to commodity procurement. The total amount spent on ARVs, and other drugs and commodities (HIV test kits, condoms, viral load reagents, VMMC kits) was about $120 million, a decrease from $126 million the previous year; total GoB expenditures also decreased from $115.7 million

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to about $112 million in the same period. PEPFAR's supplemental contribution was primarily for the procurement of ARVs (95.51%) and rapid test kits (4.49%) through the USAID Global Health Supply Chain Program – Procurement and Supply Management (GHSC-PSM).

Table 2.2.4 Annual USG Non-PEPFAR Funded Investments and Integration

Annual USG Non-PEPFAR Funded Investments and Integration					
Funding Source	**Total USG Non-PEPFAR Resources**	**Non-PEPFAR Resources Co-Funding PEPFAR IMs**	**# Co-Funded IMs**	**PEPFAR COP Co-Funding Contribution**	**Objectives**
Peace Corps	$1,973,400	$0.00	$0.00	$0.00	Appropriated funds that support allowances, transportation, medical, and training for 108 Peace Corps Volunteers. All are focused on HIV/AIDS related activities but are not PEPFAR funded
Total	$1,973,400	$0.00	$0.00	$0.00	

Table 2.2.5 Annual PEPFAR Non-COP Resources, Central Initiatives, PPP, HOP

Annual PEPFAR Non-COP Resources, Central Initiatives, PPP, HOP						
Funding Source	**Total PEPFAR Non-COP Resources**	**Total Non-PEPFAR Resources**	**Total Non-COP Co-funding PEPFAR IMs**	**# Co-Funded IMs**	**PEPFAR COP Co-Funding Contribution**	**Objectives**
Other PEPFAR Central Initiatives-BCPP	$194,577	$0	2	2	$0	GoB/BHP- Support the Botswana Combination Prevention Project
Other PEPFAR Central Initiatives-Neural Tube Defects	$295,000	$0	2	2	$0	GoB/BUMHI-Provide surveillance and data collection on Neural Tube Defects in Botswana amongst people taking DTG
Other PEPFAR Central Initiatives-BAIS	$1,000,000	$0	1	1	$0	GoB/BHP - Provide support for Botswana AIDS Impact and TB Prevalence Survey

Unclassified

Other PEPFAR Central Initiatives-Cervical Cancer	$1,709,004	$0	1	1	$200,000	Jhpiego-Prevent Cervical Cancer, especially amongst HIV positive women
Total	**$3,198,581**	**$0**	**6**	**6**	**$200,000**	

2.3 National Sustainability Profile Update

The HIV/AIDS Sustainability Index and Dashboard (SID) was completed in November 2017 to gain a better understanding of Botswana's sustainability landscape and to assist PEPFAR in making informed HIV/AIDS investment decisions. While Botswana received credit for the general coordination of the national HIV response, adoption of the Treat All program and domestic resource mobilization, significant challenges were highlighted in the SID. Among the major gaps were challenges in supply chain management and health information systems, both of which are woefully inadequate in gathering accurate data regarding commodities and patient information. Lack of accurate epidemiological and health data as well as the GoB's policy of not providing free HIV treatment to non-citizens negatively impact the goal of achieving epidemic control. The frequent rotations of senior leadership within the MoHW was also highlighted as possibly effecting MoHW's ability to effectively coordinate the national response.

COP19 Prioritization

Early in the COP19 planning process, the GoB agreed to the adoption of the Minimum Program Requirements (MPRs). This bold and swift action has put Botswana on the right path towards epidemic control. The MPRs, which are covered in greater detail in other sections of this SDS, include the following policies and practices:

1. Offer of same-day ART initiation to all newly diagnosed HIV patients across all age, sex and risk groups.
2. Adoption and implementation of differentiated service delivery models.
3. Completion of the TLD transition and removal of Nevirapine-based regimes.
4. Stop over-testing by screening better and testing smarter.
5. TB preventive treatment (TPT) for all PLHIVs must be scaled-up as an integral and routine part of the HIV clinical care package.
6. Implementing site-specific solutions to improving linkage to treatment to 95%.
7. Elimination of all formal and informal user fees in the public sector for access to all direct HIV services and related services (Botswana does not collect user fees for HIV and related services at public facilities).
8. Completion of viral load (VL) and early infant diagnosis (EID) optimization activities and ongoing monitoring to ensure reductions in morbidity and mortality across age, sex, and risk groups.
9. Data systems must be updated to collect morbidity and mortality data and providers should be trained to report it consistently.

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10. Data systems should be able to track the layering of DREAMS services.
11. Extend treatment access to non-citizens, who are estimated to account for 7% of PLHIV in Botswana.
12. Evidence of international donor resources shifting to local/indigenous partner funding.
13. Scale-up of unique identifiers for patients across all sites.
14. Develop and implement an M&E strategy to track and improve performance across the health sector.

By tackling these policies and practices head-on, Botswana is directly addressing many of the concerns raised in the sustainability dashboard. The policy of extending treatment to non-citizens stills needs to be considered by Botswana's Parliament. However, the MoHW's support of this policy change and others demonstrates a paradigm shift in thinking about what it takes to reach epidemic control. PEPFAR headquarters has also responded in kind with the promise of central funding to carry out treatment for non-citizens should the country adopt the policy. The adoption of the other MPRs, including TPT implementation and multi-month dispensing (MMD) of ARVs, will be supported through the work of PEPFAR partners and USG staff to ensure full scale-up with fidelity at all GoB sites.

The GoB has added an additional MPR in COP19 around the area of Strategic Information (SI), and PEPFAR will help strengthen Health Information Systesm (HIS) in the MoHW M&E department to build capacity for routine monitoring and reporting. The activity will be funded through Acceleration Funding in COP19 (Reference Section 6 and Appendix C). PEPFAR/B is supporting the rollout of the Botswana HIV/AIDS Impact and TB Prevalence Survey (BAIS) in COP18 and results are expected by December. Negotiations with the MoHW during COP19 will also help to institutionalize routine DQAs and strengthen data collection and data quality initiatives that will allow PEPFAR/B to report on national results at site level and the government to track results by site better in each district.

One of the barriers highlighted in past SIDs was the failure of development partners and government to build the capacity of local organizations to sustain the HIV response in Botswana. It is critical that the full range of HIV prevention and treatment services are owned and operated by local institutions, governments, and community-based and community-led organizations. This action is a priority for PEPFAR/B in COP19. The U.S. Government will shift 40% of PEPFAR funding to local organizations by October 2019, enroute to the 70% target by agency by the end of FY20.

2.4 Geographic alignment of PEPFAR investments to disease burden nationwide

In COP15 PEPFAR/B pivoted to a high-impact approach where the program was focused on scale-up and sustained SNUs. In addition, Ghanzi was targeted as a TB/HIV micro-epidemic based on the SNU having the highest TB incidence in the country and an unmet need for ART. Reaching these populations and working in sparsely populated districts is generally more expensive than serving urban and peri-urban populations. This realignment meant that PEPFAR/B's SNUs represent the districts with the highest total number of PLHIV in need of ART (Figure 2.4.1).

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In the second quarter of FY 19, PEPFAR/B was instructed to "reboot" program focus around 41 high-volume facilities and communities. The reboot exercise was meant to link legacy positives who have not initiated treatment, optimize case-finding in the facilities, scale-up same-day and fast-track initiation of ART, finding all LTFU for treatment re-initiation and ensuring all eligible general population PLHIV have a viral load test with results. In addition to the 41 government facilities and surrounding communities, four NGO Wellness Centers for KP service delivery and several KP hot spots were added to the process to provide differentiated services and ensure KP have access to KP friendly services. This new and improved way of working, which has yielded great results and strengthened facility-community implementing partner collaboration, is featured heavily in our COP 19 program implementation design.

During the PEPFAR meetings held in Washington in April 2019, PEPFAR/B was instructed to further realign its work around high volume facilities, as defined by TX_CURR > 1000. An important component of COP19 will be to ensure implementation and scale-up with fidelity of the MPRs at the selected 71 high-volume sites (Refer to Section 3 for a list of the sites). PEPFAR/B staff will provide monitoring support with MoHW/DHMTs to ensure implementation of these requirements.

The PEPFAR/B KP program follows a client-centered approach around KP hotspots. In BBSS II (2017), hot spots in Francistown, Gaborone, Ngamiland, Palapye, Chobe and Selebi-Phikwe showed an overall increase in HIV prevalence for MSM from 13.1% to 14.8% and significantly higher increase in Francistown where MSM HIV prevalence increased from 11.7% in 2012 to 24.4% in 2017. PEPFAR/B will continue to focus on the six hot spots to strengthen the already strong programs and increase focus, especially on older MSM and on FSW in Chobe, to improve performance in these areas.

Since COP 17, PEPFAR/B has supported GoB to coordinate DREAMS activities in two districts, Gaborone and Kweneng East. The program is taking shape in communities in these two districts through local sub-partners and at two facilities that are providing PrEP and post-GBV care as well as ARVs. PEPFAR/B will continue to implement its DREAMS and OVC programs in these districts, supporting prevention (including PrEP), GBV, socio-economic strengthening, and treatment when necessary for these populations in COP19.

In FY18 and FY19, PEPFAR/B focused efforts and funding through these realignment processes to invest more in what are believed to be the areas of highest need. In late 2019 Botswana expects to have preliminary results from the BAIS V, the results of which will be used to further focus the PEPFAR/B program to the areas of greatest need.

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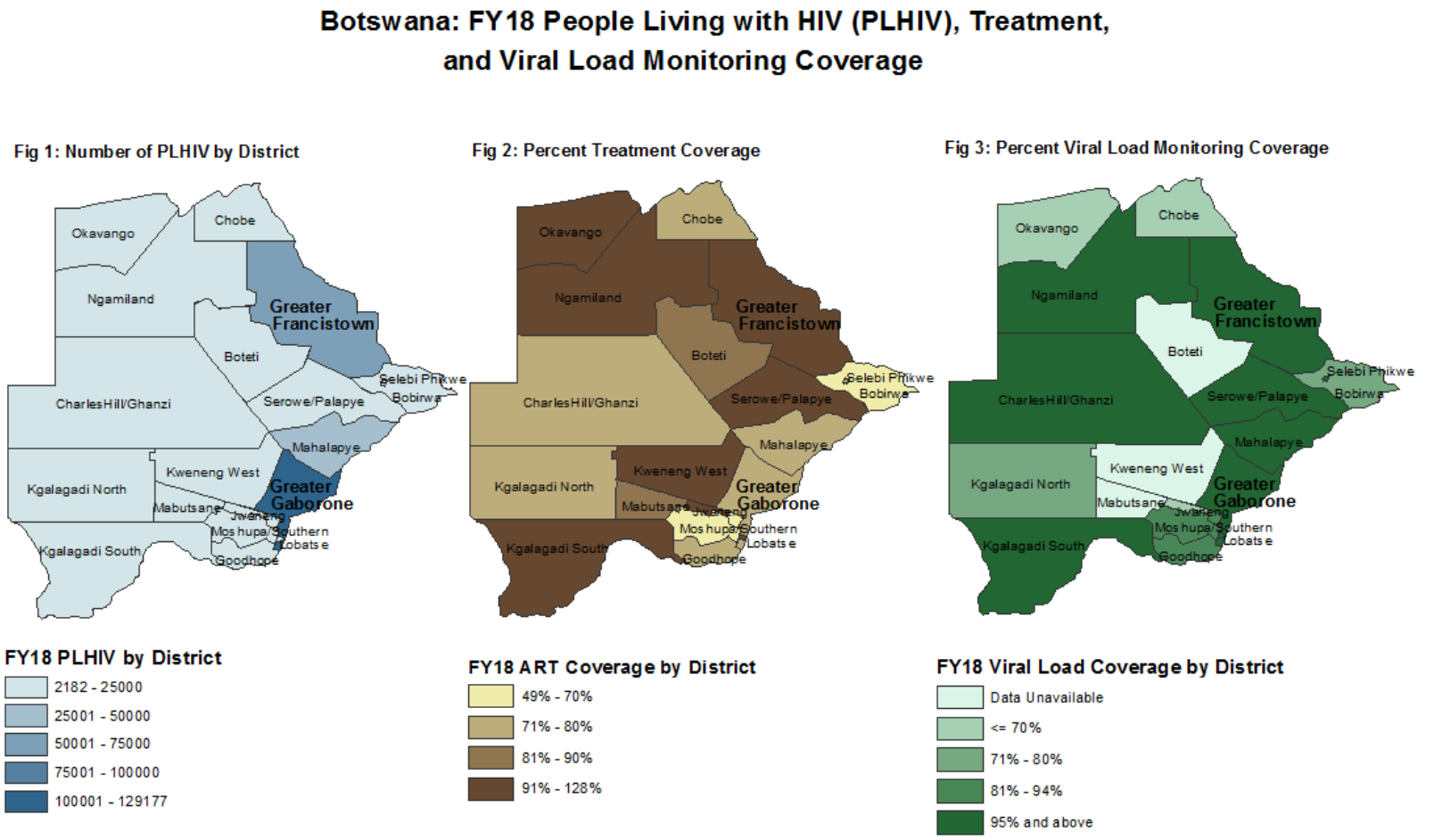
Figure 2.2 FY18 PLHIV, Treatment and VL Coverage



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2.5 Stakeholder Engagement

PEPFAR/B has continued to strengthen engagement with stakeholders by making improvements to communication processes, coordination and collaboration. There has been a focus on sharing important information through PEPFAR/B's print and electronic newsletters. Most recently, new TWGs have formed to support coordination and collaboration around the Botswana Reboot and efforts to implement Minimum Program Requirements. PEPFAR/B has continued to hold quarterly stakeholder consultations jointly with MoHW, the National AIDS and Health Promotion Agency (NAHPA) and UNAIDS. The meetings are a chance to discuss quarterly results, innovative programs and to address gaps in the national response.

As a result of improved coordination, communication and collaboration with stakeholders, we have seen an increase in both the diversity and total number of CSOs participating in quarterly and COP-specific consultations. Most notable are the new FBOs, private sector, and academic organizations that we have engaged in the past year (Refer to Appendix G).

PEPFAR/B's COP19 planning process began with an internal retreat followed by a consultation with representatives from several government ministries and agencies, including MoHW, NAHPA, National Health Laboratory, Ministry of Local Government and Rural Development (MLGRD) and the Ministry of Nationality, Immigration, and Gender Affairs (MNIGA). GoB presented on its key priorities as defined by the National Strategic Framework III and the gaps that PEPFAR could fill.

The next phase of COP19 planning included a joint consultation meeting with more than 60 stakeholders that included government, multilaterals and civil society. Following the opening presentation from MoHW, PEPFAR/B presented key components of the COP19 planning letter and discussed the policy and programming implications for stakeholders. All stakeholders participated in small group work in which the 13 MPRs were analyzed with a focus on identifying barriers to adoption and implementation. After the retreat, the TWGs continued technical discussions in preparing for the PEPFAR regional meeting in Johannesburg. The MoHW Permanent Secretary (PS) and the National Coordinator from NAHPA attended the regional meeting, as well as multilateral representatives from UNAIDS and WHO, the Global Fund and one civil society representative.

Following the Johannesburg meeting, the MoHW PS formed a new **Health Leadership Forum (HLF)** comprised of high-level representatives from all stakeholder groups to help coordinate a health sector response to HIV. The PS is the chair of this forum, which meets monthly with a mandate of joint planning, information sharing, leadership in the health sector and performance review. A technical sub-committee of the HLF was formed to categorize and make operational recommendations to the Forum around the 13 minimum requirements outlined by PEPFAR.

In implementing Botswana's Treat All Communications Strategy, the interagency team has also implemented a 10-district roadshow and distributed 1,000 facilitator kits with the PEPFAR/B's "**Have It All: The Story of the Treat All Program in Botswana"** documentary to a wide array of stakeholders. This project represents an enormous investment in strategic communications that addresses needs around demand creation and overcoming HIV-related stigma.

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Figure 2.5.1 Publicity Posters for the *Have It All* Documentary

All quarterly and COP stakeholder meetings and communications have produced feedback (verbal or written), which PEPFAR/B has used to inform program decision making. The CDC, USAID, DoD, State Department, and Peace Corps offices all participate in the above mentioned joint communications and stakeholder engagement activities.

FBO and Traditional Leaders Initiative

The new FBO and Traditional Leaders initiative has provided another platform which PEPFAR/B has been leveraging to build new relationships with churches and faith leaders, religious umbrella organizations, and traditional leaders. Following a week of consultations with 18 stakeholders in August 2018, Botswana sent three delegates (a chief, a Religious Studies professor, and a FBO program manager) to OGAC's FBO and traditional leaders' seminar in November 2018. (Refer to Appendix E for more details on the FBO Initiative)

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3.0 Geographic and Population Prioritization

A large focus in COP19 will be partnership with GoB to ensure implementation of the minimum program requirements (MPR) with fidelity across all districts and sites. The program is realigning during this COP to a national direct support program supporting MPR implementation and ensuring quality HIV service delivery. These improvements are expected to strengthen the national program so that when the BAIS V information is available, the 95/95/95 across gender and age can be programmed for (in terms of unmet need) and achieved. Once detailed and updated burden information is available (the BAIS V) a "marathon" will start – the long race to achieving epidemic control based on accurate data on the drivers of the epidemic. COP19, pre-marathon, is about training for the marathon with urgency. We are preparing our systems (prevention, care and treatment, data systems, etc.) to be able to be able to perform well in the race.

Consistent with this strategy, the site realignment to 71 sites is one part aligning assets and funding based on need and to ensure OVC, DREAMS and VMMC, etc. is aligned to the highest disease burden areas and a second part aligning assets and funding in a maintenance and training posture that will 1) best support the GoB implementation of the MPRs nationwide and 2) allow for partner performance improvements across the full cascade for the greatest number of PLHIV. The new list of sites was selected with these goals in mind. The site list now has fewer partner supported PEPFAR sites (53) with smaller volume sites having been removed. Of the 53 implementing partners-supported sites, 35 are currently included in the reboot activities. These 53 sites are still in high burden areas. The balance of the 71 sites (18) represent substantial TX_CURR (per the MOH Data Alignment activity) but were not previously considered PEPFAR sites or received only central support. As a whole, the list of 71 sites is intended to enable PEPFAR and GoB to achieve National MPR implementation and quality service delivery with impact and demonstrate that achievement.

Reboot activities to improve partner performance will continue in the 53 sites supported by PEPFAR implementing partners. Efficiencies have already been identified as the partners and the PEPFAR/B team amass evidence on best practices to make this effort less work-intensive. Partners will work to sustain the improvements and ensure early adoption of all relevant MPRs as the GoB moves forward with MPR implementation.

Table 3.1.1 Priority Sites for COP 19

The Districts and Sites **bolded** indicate new district and sites to PEPFAR in COP 19

BACKGROUND INFORMATION

After the COP DC meeting, 71 sites in **Bobirwa,** Francistown, Gaborone, Goodhope, Kgatleng, Kweneng East, **Lobatse**, Mahalapye, Moshupa, Ngamiland, North East, Okavango, Palapye, Selibe Phikwe, Serowe, South East, Southern, Tutume have been chosen for PEPFAR support:

Airstrip Clinic
Area W Clinic
Athlone Hospital
Bamalete Lutheran Hospital
Bobonong Primary Hospital
Boikhutso Clinic
Bontleng Clinic
Borakalalo Clinic
Borolong Clinic
Boseja clinic
Botshabelo Clinic
Botshelo Clinic

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Botswelelo Clinic	Morwa Clinic
Broadhurst III Clinic	Moshupa Council Clinic
Broadhurst Traditional Area Clinic	Moshupa S.D.A Clinic
Deborah Retief Memorial Hospital	Nata Clinic
Extension 3 Clinic	Newtown Clinic
Francistown Tebelopele Centre (KP)	Nkoyaphiri Clinic
Gaborone Tebelopele Centre (KP)	Nutrition Clinic
Gaborone West Clinic	Nyangabgwe Referral Hospital
Gerald Estate Clinic	Old Naledi Clinic
Goodhope Primary Hospital	Palapye Primary Hospital
Gweta Primary Hospital	**Peleng Central Clinic**
Jubilee Clinic	Phase II Clinic
Kadimo Clinic	Phuthadikobo Clinic
Kagiso Clinic	Princess Marina Referral Hospital
Kanye Main Clinic	S.D.A Kanye Hospital
Kediretswe Clinic	Scottish Livingstone Hospital
Lentsweletau Clinic	Sebina Clinic
Lerala Clinic	Sefhare Primary Hospital
Lesirane Clinic	Sekgoma Memorial Hospital
Letsholathebe II Memorial Hospital	Serowe Clinic
Mahalapye Hospital	Shoshong Clinic
Makakatlela Clinic	**Tapologo Clinic**
Masego Clinic	Tati Siding Clinic
Masunga Primary Hospital	Tatitown Clinic
Maun Clinic	**Tawana Clinic**
Maun General 24 hours Clinic	Thamaga Primary Hospital
Maun Tebelopele Centre (KP)	Tlokweng Main Clinic
Maunatlala Clinic	Tonota Clinic
Mmadinare Primary Hospital	**Tsopeng Clinic**
Moeti (Boyei) Clinic	Tutume Primary Hospital
Mogoditshane Clinic	Village Clinic
Molepolole Tebelopele Centre (KP)	

In sum, COP19 will support the GoB to implement the MPRs and deliver quality HIV services. COP19 should position Botswana to move quickly towards 95/95/95 once the BAIS V data is made available. COP19 is a completely new way of thinking about the program and therefore about program-related work-flow. The locations and sites were selected as the underling framework for maximum impact and success of nationwide MPRs and HIV service delivery improvements. How PEPFAR Botswana accomplishes this will be heavily informed by the TWG plans, which will likely require different levels of effort for different DHMTs and different MPRs. It will also be informed by partners' (IMs) ability to scale and sustain the reboot improvements.

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Figure 3.1 Map of COP19 Sites

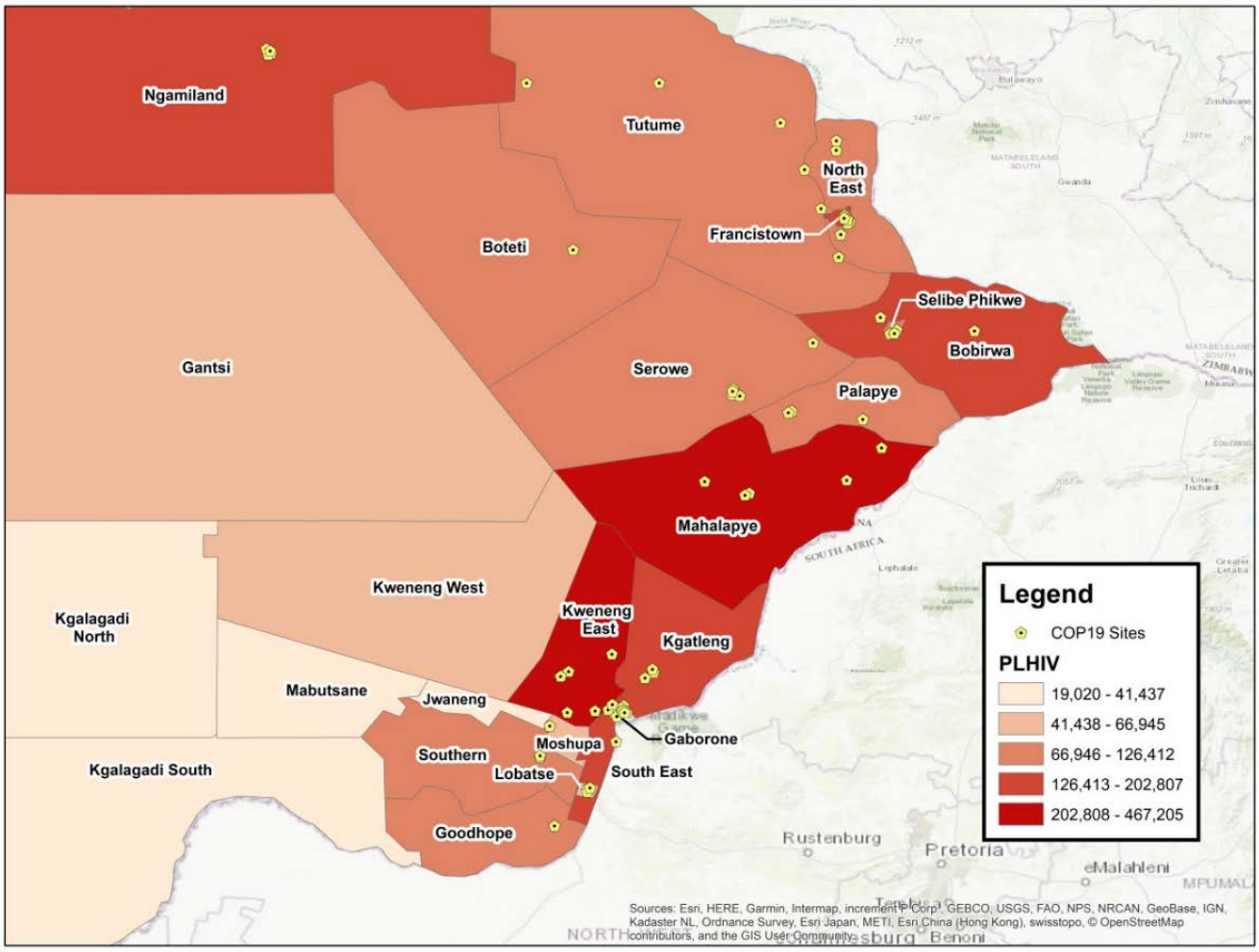

Table 3.2 Current Status of ART saturation (REQUIRED TABLE)

Current Status of ART saturation				
Prioritization Area	**Total PLHIV/% of all PLHIV for COP19**	**# Current on ART (FY18)**	**# of SNU COP18 (FY19)**	**# of SNU COP19 (FY20)**
Attained	None	None	0	0
Scale-up Saturation	187,493 (51%)	88,510	8	
Scale-up Aggressive	None	0	0	0
Sustained	79,117 (21%)	51,095	5	13
Central Support				

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4.0 COP19 Reboot Program Activities and MPR Implementation for Epidemic Control in Priority Locations

4.1 Overview of PEPFAR Botswana Reboot

Botswana was once an international leader in the response to HIV/AIDS. Former President Festus Mogae ensured the world was aware of the HIV crisis in Africa, and Botswana became the first African country to roll out free treatment to its citizens. Its Prevention of Mother to Child Transmission Program (PMTCT) lowered the rate of new MTC infections to under 2%, performing better than many Western countries. Botswana has also been a world leader in HIV and TB research, including groundbreaking and informative studies on TB preventative therapy, the use of Pre-Exposure Prophylaxis (PrEP) and combination prevention which has helped inform programs around the globe.

Despite these many strengths, the collective response to HIV in Botswana has stalled. After dropping rapidly for nearly a decade, the number of new HIV infections has stagnated in recent years. New infections among adolescent girls and young women remain much higher than other populations. Programs aimed to link people living with HIV to treatment, retain them in care, and help them remain virally suppressed lag behind neighboring countries. Men, in particular, are failing to access care and treatment services and continue to spread the virus at alarming rates. There are more than 20,000 HIV-positive men who are undiagnosed, and another 50,000 who are either not virally suppressed or who know their status but are not on ART. It is impossible to decrease new infections and reach epidemic control if the men are not virally suppressed.

The COP19 Planning Letter provided guidance to PEPFAR/B to "reboot" current implementation and refocus and intensify efforts to strengthen the existing program towards rapid achievement of epidemic control and the 95-95-95 targets across all sex and age bands. Health care workers at the site level must prioritize same-day treatment and stem attrition from the treatment continuum. GoB leadership has also realized the need to do things differently. There is a need to both eliminate structural barriers impeding Botswana's success at reaching epidemic control, while at the same time ramping-up and focusing efforts to ensure that all HIV-diagnosed individuals are immediately linked to treatment, retained in care and remain virally suppressed.

Reboot is a chance to start afresh, with focus on what it will take to achieve sustained HIV epidemic control. It will take a coordinated effort from Ministry officials, DHMTs, international donors like PEPFAR and their implementing partners, multilaterals, civil society and private practitioners. This effort is being coordinated by the MoHW, and all stakeholders are being brought to the table.

Core to reboot are improvements and focus in the following areas:

- **HIV Case Identification**: Optimized PITC that utilizes risk and/or symptom-based screening in addition to testing of pregnant women attending antenatal clinics, ensuring 100% testing through high yielding modalities (TB, STI); reaching men through inpatient, emergency

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departments and provision of afterhours and weekend services in selected high volume facilities.

- **Same-Day and Fast-Track Initiation (within 7 days) of ART**: All clients who test HIV positive must be handed over to a nurse prescriber or physician for same-day ART initiation. Prescribing and dispensing ART to clients on the same day that they are diagnosed is preferred and the first objective of the facility. In cases where this is not possible, community partners will work with facility partners to ensure ART to the client within one week of diagnosis.

- Having **Nurse Prescribers (NP)** available and supportive to facilitate same-day and fast-track initiation is essential, even during extended hours. Other support services sush as pharmacy and phlebotomy must avail services to facilitate the same. The NP have been called "game changers" in Botswana's ability to improve linkage to treatment.

- **Viral Load Access**: The success of the national response depends greatly on all clients on treatment maintaining a suppressed viral load – which can only be tracked through viral load testing. All DHMTs and private practices must devise systems for ensuring every client on ART receives at least one viral load test per year and receives those results. Providers must track clients who miss viral load and ensure they are linked back for viral load.

- **Patient Retention in Treatment:** All HIV service providers must devise strategies for retaining clients on ART, creating and instituting systems for monitoring missed appointments and taking action before clients get lost to care. Providers must also and devise case-management plans for potential defaulters, utilizing community partners to provide retention support and track and bring defaulters back into treatment.

- **M&E:** Reporting results of case identification, ART initiation, viral load tests and retention in electronic patient management systems is just as important to the success of the national response as the work itself. Without good data in electronic systems and shared in the national data warehouse, Botswana cannot reliably show success at attaining the 95-95-95 goals.

These interventions involve facility and community based approaches with focus on 53 high burden sites and surrounding communities for the general population and six key population hot spots. Four PEPFAR partners are actively involved with reboot: APC, LINKAGES, ITECH and BUMMHI. All increased collaboration among themselves in the facilities and communities to improve program results. They have developed protocols that guided data sharing and client transfer from facility to community partners. The following lays out activities for reaching both legacy positive cases (retrospective cases) and currently identified PLHIV (prospective cases).

Retrospective Approach

Figure 4.1.1 shows the process used to identify legacy positives for the reboot community partners to link to treatment where they will be met with improved same day/fast track initiations. PEPFAR partners

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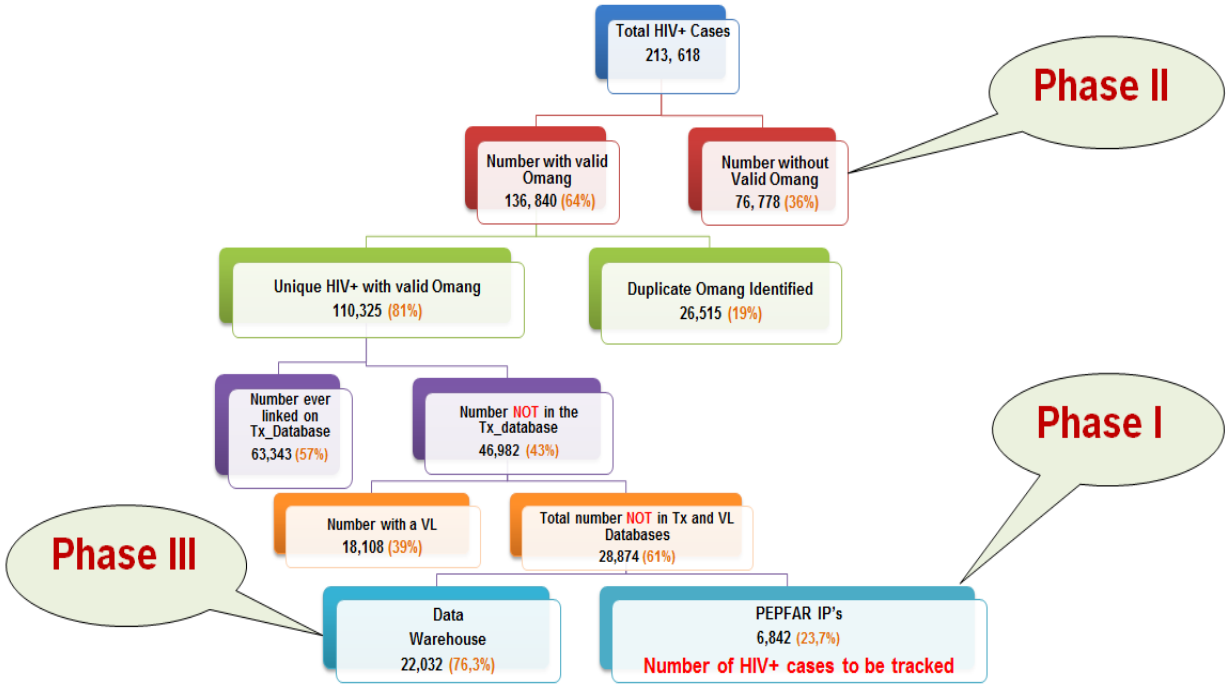
examined the records of all HIV+ cases and narrowed down the first cohort for tracking and tracing activities to 6,842 legacy positives; this is Phase I of the retrospective process. During this exercise, which included checking contacting clients and checking records against IPMS database and facility records to confirm the clients' claims, it was discovered that as many as half were already on treatment, but the records were not updated to show this information. PEPFAR/B will work with the MoHW on improving patient record management (Refer to Section 6) to prevent these data errors. After identifying the client's treatment status, the community partners followed up on those not on treatment through phone and interpersonal contact (including use of expert clients) to link them back to treatment. In COP19, PEPFAR/B will implement activities for Phases II and III of the retrospective process so that all HIV clients are located and their status is up to date and those not on treatment will be provided ART.

Figure 4.1.1 Reboot strategy (Retrospective process)



Prospective Approach

Figure 4.1.2 demonstrates the prospective approach for linking newly diagnosed patients. The goal of the prospective phase is to increase same-day initiation vis-à-vis facility based approaches. Health Care Workers, Expert Clients, Social Workers, Community Health Workers and linkage "Ambassadors" were all employed as needed at various stages to ensure the client is immediately initiated on ART. Patients diagnosed as HIV positive are directly linked with a Nurse Prescriber who can counsel and provide the necessary treatment the same day. If patients are not ready to link within three days, community and facility partners will work collaboratively to ensure initiation on ART within seven days of diagnosis utilizing expert clients to ensure patient readiness. There is a warm hand-over of clients not linked within

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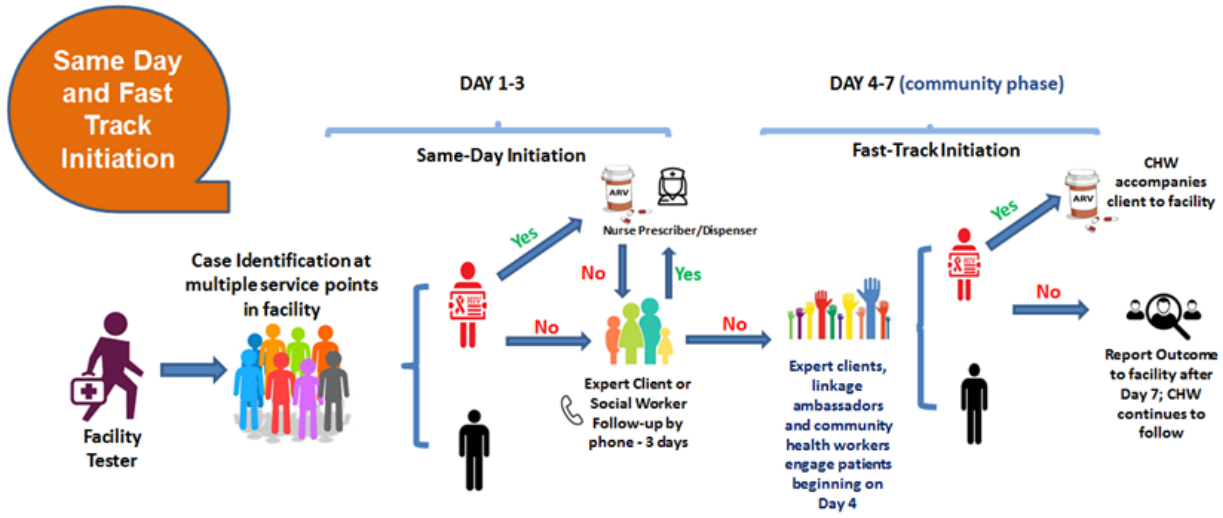
three days in the facility by facility partners to community partners on Day 4. Community partners intensify efforts to ensure linkage of clients to treatment by Day 7.

Figure 4.1.2 Reboot strategy (Prospective process)



A tracking and reporting tool that captures granular data and displays them on a dashboard was developed for both retrospective and prospective processes. Each week during Reboot, Implementing Partners reported the prior week's data. Each partner compiled reboot data site by site and populated the relevant sections of the tools every Thursday. Thereafter, all partners met to verify and aggregate the data generated and captured for the week into one master data set that was shared with PEPFAR Technical Working Groups (TWGs). The PEPFAR SI TWG used the data set to update reboot dashboards and generate charts and tables to present at reboot meetings held at the MoHW.

PEPFAR/B worked together with MoHW to improve retrospective and prospective linkage to ART, retention, and viral load coverage and suppression. MoHW has since taken ownership and has begun to lead reboot meetings. A key evidence of GoB buy-in for reboot and improvement initiatives are the Savingrams developed and shared with DHMT's for each of them to implement new policies and procedures in their facilities. The list of Savingrams have included directives on:

- February 11 – "Botswana Government Commitment to Three Months Multi-Month Dispensing for Antiretroviral Treatment". Covering multi month scripting and multi month dispensing of ARVs for stable patients.
- February 27 – "Rebooting HIV Services to Achieve Epidemic Control". Covering HIV Case Identification, Same day and Fast Track Initiation, Viral Load Access, Patient Retention and Lost-to-Follow Up and Defaulter Tracking
- April 10 - "Updating of Longitudinal Records for HIV Patients". Covering Patient Information Monitoring and data collection collaboration between USG and MoHW.

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- April 15 – "Additional Initiatives to Support Rebooting HIV Services to Achieve Epidemic Control" Covering Same Day Initiation, TB Preventative Therapy, Active Partner Notification, HIV Self Testing and Tracking of HIV+ Non-citizens

The reboot structures established and processes operationalized by PEPFAR Botswana within two months resulted in increased linkage to treatment (LTT) from 62% to 76% (overall) and 71% to 86% (citizens only), improved VL Coverage from 83% to 96% (VL suppression is 93%), increased yield from 4.5% to 6.1%; and increased retention from 92.8% to 98%.

Based on lessons learned, PEPFAR/B will continue with reboot interventions to increase fast-track ART initiation rate to 95% and same-day initiation to at least 50% at all sites across age, sex, and risk groups. PEPFAR Botswana will ensure that the clients are retained in treatment and virally suppressed.

Meanwhile, MPR efforts are coordinated by the MoHW and the NAHPA through the HLF, with support from other GoB ministries, international donors including PEPFAR and the Global Fund, multilateral partners including WHO and UNAIDS, implementing partners, civil society members and representatives from the private sector.

4.1.2 Case Identification

In COP19, PEPFAR/B will prioritize specific age bands in children, AGYW, adult men and adult women as target populations for focused programming to achieve the 95-95-95 goals. The plan encompasses activities across prevention, HTS, care and treatment services, HIV/TB, laboratory and systems support (i.e. HRH, commodities). To enhance recruitment and retention efforts, focused communication strategies will be utilized to increase demand creation and awareness of Treat All in both scale up and sustained SNUs. To find the missing HIV positive cases, optimized PITC utilizing risk and/or symptomatic screening, facility active partner notification and HIV self-testing will be the key case identification strategies utilized in COP19.

As instructed in the PEPFAR Planning Letter, all community testing has been halted and will remain in the pause stage until otherwise instructed by S/GAC. Only testing of key populations in the community has been included as a case finding strategy approved by S/GAC.

This section describes the COP19 approaches for optimized PITC or initiating case identification strategies for both general populations and sub-population groups in facilities or with key populations at hot spots in the community.

4.1.2a Case identification strategies relevant to adult men and women and AGYW

During COP19 planning and before reboot, PEPFAR/B categorized SNUs according to ART gap to guide HTS and linkage to treatment modality deployment (Table 4.1.1). Three SNUs (Greater Francistown, Mahalapye and Greater Gaborone) were classified as priority districts with highest unmet need for HTS

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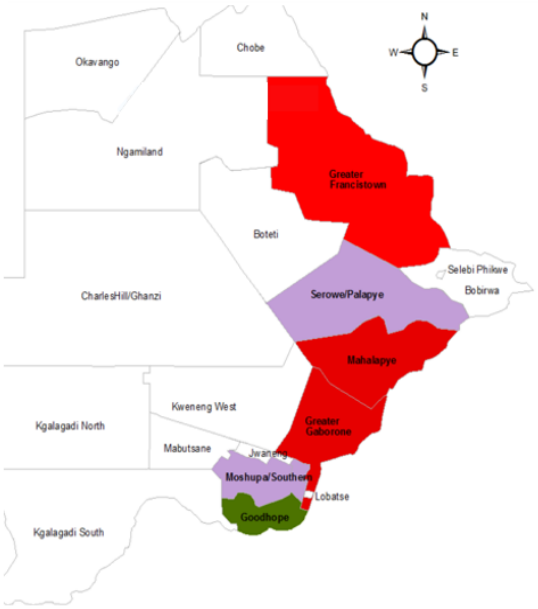
and low treatment saturation. Serowe/Palapye and Southern have medium unmet need and are on course to achieving epidemic control. Goodhope is the district with the lowest unmet need for HTS with the remaining gap in treatment being very small and concentrated among men aged 30-39.

Table 4.1.1 HTS and Linkage to Treatment Strategies modality deployment based on SNU prioritization



Highest Unmet Need for HTS	Medium Unmet Need For HTS	Lowest Unmet Need For HTS

Facility
• **Index testing** for all positives, including ANC partner testing (& **HIVST**)
• **Optimize PITC**
  • 100% coverage among TB, STI, Emergency and In-patients
  • Risk/targeted screening at OPD
  • Eliminate testing at low volume/yield modalities
• Expanded **Weekend & Afterhours** services, use of **Warmline**
 	
Community
• **KP testing**, including their partners, clients and children
	Facility
	• **Index testing** for all positives, including ANC partner testing (& **HIVST**)
	• **Optimize PITC**
	  • 100% coverage among TB, STI, Emergency and In-patients
	  • Risk-based screening with plan to transition to targeted or diagnostic testing in OPDs where positivity rates are lowest
	
	Community
	• **Targeted KP testing**, including their partners, clients and children
		• **Index testing**
		• **Diagnostic testing**
		• Select, targeted/risk testing at select high volume/high yield modalities
		• Testing of exposed babies at ANC clinics
		• **Transition planning for shift to MOH**
		
		Community
		• **Targeted KP testing**,

• Accompanied Referrals to treatment: Direct/warm handover of patients from testers to Nurse Prescribers
• Support Start/Initiate and Transfer-out at Hospitals
  ▪ Inpatient patients
  ▪ Patients receiving referral services
  ▪ After-hour clients, clients identified at sites with no IDCC		

Following the COP19 planning session in Washington, a new list of 71 high burden sites was created based on TX_CURR where PEPFAR/B can best support the GoB implement the MPRs nationwide and allow for partner performance improvements across the full cascade for the greatest number of PLHIV were selected. The site list now has fewer partner supported PEPFAR sites (53) with smaller volume sites having been removed. Optimization of case finding will continue in those 53 reboot sites.

In COP19, PEPFAR/B is required to limit its case-finding strategies to the following for the general population: a) optimized PITC that utilizes risk and/or symptom-based screening and testing and ensuring testing of pregnant women attending antenatal clinics, b) facility-based index partner testing that conforms to PEPFAR guidance and c) HIV self-testing implemented as a platform for strengthening index testing.

- **Optimized PITC utilizing risk and/or symptomatic screening -** Implementation of optimized PITC that utilizes risk and/or symptomatic screening is part of the COP19 planning letter requirement for HTS. The PEPFAR/B team, in collaboration with the facility based implementing partner, revised and piloted a risk and symptomatic screening tool in five high volume facilities as part of reboot process. In this regard, overall strategy is to limit case-finding to optimized PITC that utilizes risk and/or symptom-based screening in addition to testing of pregnant women attending

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antenatal clinics, ensuring 100% coverage and testing at TB, STI, inpatient, accident and emergency departments.

- **Rapid scale-up of facility based index partner testing with fidelity for all positives including ANC partner testing** – By ensuring that newly identified PLHIV and those enrolled in care in the last 24 months are offered partner elicitation services. Non-suppressed viral load registers will be used as a starting point for index testing of long-term HIV clinic clients found to have unsuppressed viral load during routine testing. Recently, MoHW allowed for the implementation of active partner notification. This approach will ensure that different options for reaching index sex partners are implemented depending on agreement between the index patient and provider for each partner (contract referral, provider referral, dual referral, self-testing). Meanwhile, the PEPFAR/B team carefully evaluated the contribution of index testing to overall case identification and yield during implementation of Reboot. Overall coverage for index improved from 82% in FY19Q1 to 90% during initial reboot implementation (February 8- 31 March, 2019). The yield also increased significantly from a pre-reboot of 14% to 20% during reboot. Implementation of active partner notification will improve the reach and coverage of this is testing strategy. The National Partner Notification SOP is currently being updated to align with WHO and PEPFAR guidance by including a section on active partner notification. Table 4.1.2 below is a Gantt Chant outlining the phased roll-out of Active Partner Notification.

Table 4.1.2 Phased Roll-out of Active Partner Notification

ACTIVITY	Preparation (April 15 –May 15)			PHASE One (May 20-31st)			PHASE Two (June 3 -15th)			PHASE Three (June 17-30)		
	WEEK 1	WEEK 2	Week 3	WEEK 4	WEEK 5	WEEK 6	WEEK 7	WEEK 8	WEEK 9	WEEK 10	WEEK 11	WEEK 12
Savingram on Active Partner notification Released to DHMT's	x											
District sensitisation on Savingram		x	x	x	x	x	x	x	x	x	x	X
Updating of the national Index testing curriculum to include Active PN services (PEPFAR TA support)		x	x									
Updating APN tools (PEPFAR TA support)		x	x									
Develop job-aids, role-plays, messaging (PEPFAR TA support)		x	x									
Training of Trainers (POs, program assistants)				x								
External TDY Support (TBD)				x	x	x						
Phase 1: Training of lay counselors at high volume sites				x								
Immediate rollout of active partner notification at high volume sites				x	x	x	x	x	x	x	x	x
Phase 2: Training of lay counselors at mid volume sites (guided by GOB HTS_POS ranking)						x						
Immediate rollout of active partner notification at mid volume sites (guided by GOB HTS_POS ranking)							x	x	x	x	x	X
Phase 3: Training of HCAs to the remaining national sites									x			
Immediate rollout of active partner notification to the remaining national sites									x	x	x	X
Robust on-site mentoring (ongoing)			x	x	x	x	x	x	x	x	x	x

- **Scale-up of HIV self-testing (HIVST), including provision of self-test kits for partners of ANC women** – HIVST is one of the COP19 key minimum requirements for the Botswana HTS program. Following intensive engagement with MoHW management, a phased, country-wide roll-out has

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started. HIVST will be used to address major access and social barriers to HTS uptake among populations with the greatest unmet need such as adult men and adolescents. HIVST will be strategically deployed to screen AGYW and their partners, male partners of ANC clients and young at-risk men who would otherwise not present at facilities. HIVST will achieve greater early diagnosis of PLHIV unaware of their status, improve HTS program positivity and help optimize human resources. Additionally, PITC clients who do not volunteer to bring their partners for index testing will also be offered self-testing kits. (Refer to Table 4.1.1 above)

4.1.2b Case identification strategies specific to major population groups

Adult Men - 15 years and above:

As shown in Table 4.1.3 below, there are many adult men aged 30 and above who are HIV positive but do not know their HIV status (a total of 5,394), mainly from Greater Gaborone. COP19 prioritizes finding these older men and ensuring they are linked and initiated on treatment. Furthermore, there is a significant proportion of younger men aged 20-29 who are HIV positive and do not know their status. Therefore, targeting young adult men is also a key HTS priority for COP19.

Table 4.1.3 COP19 HTS_POS Targets by SNU for Adult Men 15 years+

SNU	15-19	20-24	25-29	30-34	35-39	40-44	45-49	50+	Total
Bobirwa	2	5	21	46	49	37	21	29	**211**
Francistown	13	18	78	57	47	16	12	33	**272**
Gaborone	50	127	149	160	132	79	47	25	**770**
Goodhope	4	8	16	99	23	17	11	15	**193**
Kgatleng	10	19	51	55	71	61	37	45	**349**
Kweneng East	39	83	155	229	253	296	270	415	**1739**
Lobatse	3	27	86	84	32	8	8	0	**249**
Mahalapye	50	95	181	291	329	223	178	204	**1551**
Moshupa	7	13	22	44	52	55	36	54	**282**
Ngamiland	3	5	13	16	30	12	7	21	**107**
North East	14	22	44	69	94	76	58	109	**486**
Palapye	3	14	48	62	23	15	8	8	**182**
Selibe Phikwe	1	7	17	26	26	106	86	158	**428**

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Serowe District	1	8	33	45	21	15	8	6	**138**
South East	17	34	54	89	119	109	98	140	**660**
Southern	12	21	35	75	86	95	58	68	**449**
Tutume	8	17	33	65	57	63	51	65	**359**
Total	**238**	**523**	**1035**	**1513**	**1445**	**1282**	**994**	**1396**	**8426**

Case identification among men has remained lower than women. Of the 6,362 cases identified during FY19 Q1-Q2, by the facility implementing partner, 42.6% were adult men aged 15-50 years and older. In Botswana, as in other countries in Sub-Saharan Africa, men are less likely than women to present at facilities to seek health care. However, lessons learned from reboot have helped the country team identify specific strategies to identify and diagnose men. In FY20, a strategic mix of HTS modalities focused on improving overall yield and case identification among men while also achieving efficiencies through reduction of over-testing will be implemented. To increase case identification of adult men, the following approach will be implemented in COP19:

Optimized PITC

- *Screening:* Utilizing risk and/or symptomatic screening tools to increase OPD yield and reduce over-testing: the PEPFAR/B team in collaboration with the facility based implementing partner revised and piloted a risk and symptomatic screening tool in selected (5) high volume facilities as part of the reboot process. The tool will be utilized in outpatient department as follows:
    - *Risk based screening* as a strategy for reducing over-testing and improving yield: All adults, adolescents and children accessing OPD will be screened for HIV risk with those at risk being offered HIV testing. In FY19Q1-Q2, 54.8% of all cases identified in OPD were males.
    - *Diagnostic testing* of patients who present with signs or symptoms suggestive of HIV. As mentioned above, men are less likely to present at facilities seeking health care and as such are more likely to present very late with clinical symptoms. Diagnostic testing will be implemented in medical outpatient department targeting adult male patients (<30) seeking acute care.
- *Rapid Scale-up of Index partner testing*: Facility-based testing generally reaches more females than males. Given the large remaining gap and corresponding COP19 target among adult men, PEPFAR/B plans to conduct partner elicitation among HIV positive women in order to access their male counterparts for testing. Index cases will also be sourced from new cases identified among ANC women and from PLHIV in HIV clinics. Non-suppressed viral load registers will also be used as starting point for index testing of partners of women who are long-term HIV clinic clients found to have unsuppressed Viral load during routine testing. The recent approval by MoHW allowing active partner notification implementation will ensure that different options for reaching men are

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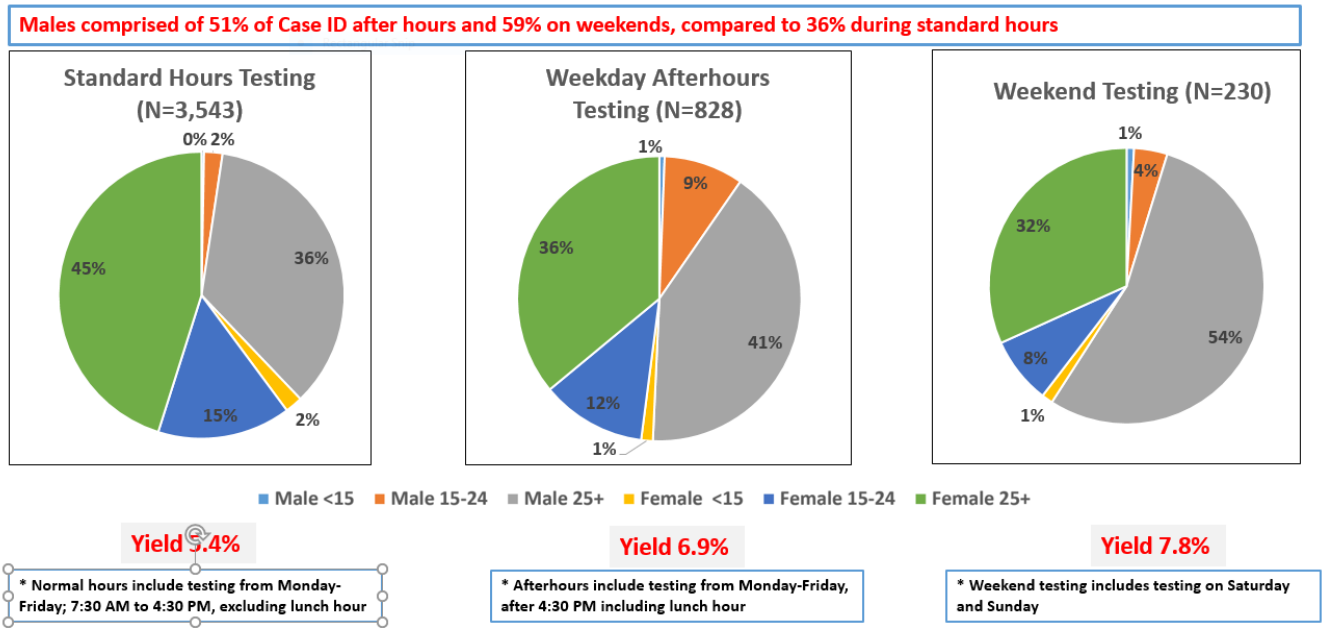
implemented depending on the preference of the index patient and for each partner (contract referral, provider referral, dual referral, self-testing).

- *Reaching adult men in facilities through weekend and afterhours services:* Optimizing other successful strategies for identifying men will be key in meeting COP19 targets. During Reboot, the implementation of afterhours and weekend services significantly improved the proportion of adult males identified. For instance, only 17% of the cases identified were adult males 25+ when services were provided during normal hours. However, the proportions increased to 40% and 55% when services were provided during afterhours and on weekends, respectively (See Table 4.1.4 below). The yield also increased significantly from 5% during standard hours to 5.9% and 8.5% respectively during after-hours and weekend services.

Table 4.1.4 Reaching adult men through weekend and afterhours (Pre-Reboot and Reboot)



- *HIV self-testing targeting sex partners of ANC attendees and of at-risk AGYW presenting at youth friendly clinics:* To reach adult men, self-test kits will be given to pregnant or post-partum women presenting at post-partum or ante natal care who have a male partner with unknown HIV status. Women presenting at health facilities for STI and TB treatment will also be leveraged to reach their male sex partners through HIVST. ANC women, who do not volunteer to bring their partners for index testing, will be offered self-testing kits. Refer to Table 4.1.1 above for detailed HTS and Linkage to Treatment Strategies modality deployment by SNU.

- *Male-friendly corners in facilities*: Lessons learned from Lesotho have demonstrated that the introduction of male-friendly corners has potential to improve male health seeking behavior in addition to HIV testing and linkage to care. A phased roll-out of male friendly corners was started as part of the reboot strategies for improving case identification among men. Three sites (including Lesirane, Nkoyaphiri and Princess Marina Hospital) targeting men through provision of

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extended and weekend services have engaged male testers to facilitate a welcoming environment for male clients. The next phase is to provide integrated services including sexual health and wellbeing for men and services for non-communicable diseases such as diabetes and blood pressure in addition to HIV testing. Red carpet/fast pass to reduce waiting time for men is also used to complement implementation of male friendly corners. (Refer to Table 4.1.1 above).

- *Expanded testing at Accident and Emergency (A&E) departments:* Hospital A&E departments continue to be strategic locations for identification of undiagnosed HIV positive young adult men. During Reboot, while just over 9% of all cases identified in facilities were at A&E departments, 35% were men aged 20-39 years. In addition to expanding Health Care Auxiliaries (HCAs) at all A&E departments and prioritizing testing of men, COP19 will support expansion of testing to include family members and sex partners of A&E patients. HIV eligibility screening for family members in A&E waiting areas will also be scaled-up. HIV testing will also be offered to all inpatients clients including adult men admitted in hospitals and other inpatient facilities. (Refer to Table 4.1.1 above)

- *Reaching adult men through screening of presumptive TB patients:* Collaboration between facility HIV testing and TB/HIV implementing partners has significantly improved identification and HIV screening of presumptive TB patients. In most facilities, twice as many women than men present for care. Presumptive TB identification was significantly higher in men than women age 25+ (54% versus 37%) reinforcing the value of this strategy for identifying men. COP19 will include strengthening intensified TB screening and HIV testing among males aged 25+. (Refer to Table 4.1.1)

- *Using programmatic data to implement Universal HIV testing among adult males aged 35-55:* Analysis of programmatic data shows a higher yield of over 10% among adult men aged 35 and 55 (Table 4.1.5). Overall epidemiologic data also shows this age and sex group as having high HIV prevalence and low knowledge of status/ART coverage. PEPFAR/B COP19 strategy will implement universal HIV testing among this defined group through use of the screening tool. The plan is to screen all adults accessing OPD and specifically ensure 100% testing among adult men aged 35-55. (Refer to Table 4.1.1)

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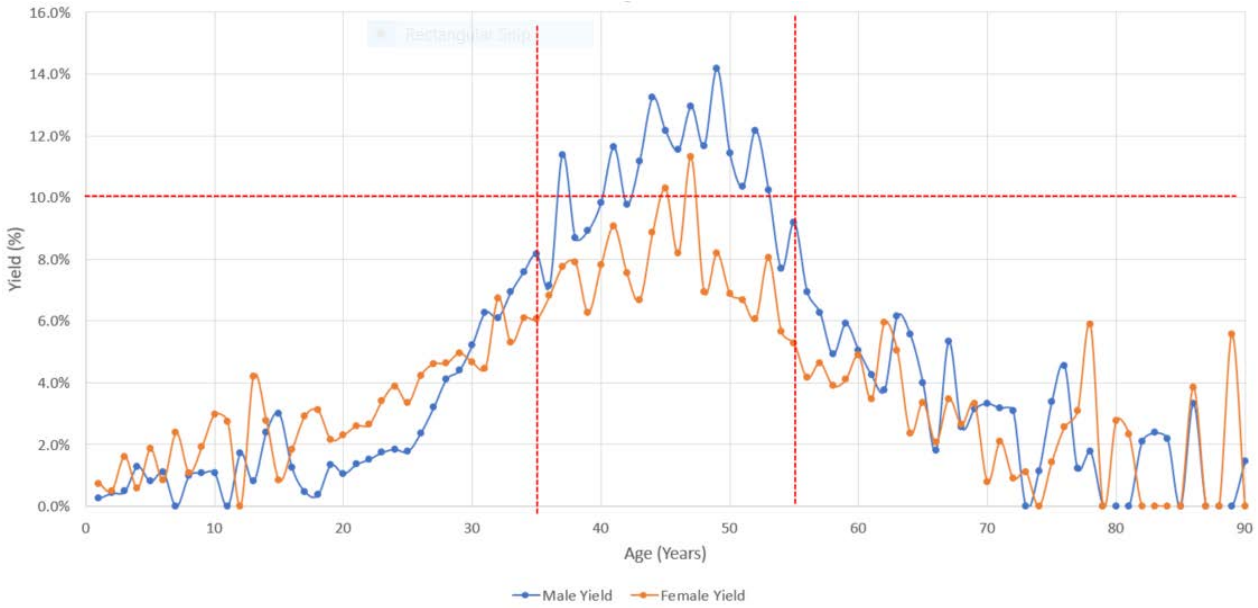
Table 4.1.5 Facility Testing Yield by Age and Sex, FY19Q1



Adult Women – 15 years and above

In FY19 Q1-Q2, a total of 73,545 women aged 15 years and above had been tested for HIV, and 3,582 of them were identified HIV positive, that is a yield of about 5%. The women in this age bracket have a prevalence of 34.2% (UNAIDS 2017), the highest among all age/sex bands. The attainment analysis also shows the greatest unmet need cutting across all age bands in three SNUs of Greater Gaborone, Mahalapye and Southern (Table 4.1.6). To increase uptake of HTS, the implementing partner will continue to accelerate implementation of targeted innovative testing modalities consistent with the COP19 requirements to identify more cases among adult women and link them to care and treatment. Therefore, a key focus for COP19 will be to ensure that women are diagnosed and linked to treatment.

Table 4.1.6 COP19 HTS_POS Targets by SNU: Adult Women 15+

SNU	15-19	20-24	25-29	30-34	35-39	40-44	45-49	50+	Total
Bobirwa	25	73	92	45	39	29	20	25	**349**
Francistown	29	60	69	64	46	27	41	12	**347**
Gaborone	40	137	195	194	104	45	50	25	**790**
Goodhope	3	7	8	8	5	3	2	3	**41**
Kgatleng	11	49	45	70	39	43	19	31	**307**
Kweneng East	64	128	187	327	275	327	154	217	**1679**

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Lobatse	7	59	54	43	23	8	8	0	**203**
Mahalapye	49	81	93	122	68	50	30	84	**578**
Moshupa	9	23	31	52	47	37	37	44	**280**
Ngamiland	17	107	130	115	52	26	21	8	**478**
North East	18	40	65	80	89	78	58	83	**512**
Palapye	18	22	36	26	21	16	15	8	**161**
Selibe Phikwe	17	50	59	29	14	15	8	458	**650**
Serowe District	24	31	36	34	14	21	12	8	**180**
South East	23	61	83	121	134	113	74	83	**691**
Southern	15	39	52	87	77	58	63	38	**428**
Tutume	8	32	14	32	50	4	3	3	**148**
Total	**377**	**1001**	**1251**	**1449**	**1097**	**900**	**616**	**1131**	**7823**

Optimized PITC targeting women through:

- *Utilizing risk and/or symptomatic screening tools to increase OPD yield and reduce over-testing.* As highlighted earlier, PITC approaches tend to reach more females than males. Given the targets, PEPFAR/B estimates 80% of the adult women targets will be reached through the other PITC modality. COP19 funds will support implementation of stringent risk and symptomatic screening in high volume facilities as part of the Reboot process. The tool will be utilized in outpatient departments as follows:
    - *Risk based screening* as a strategy for reducing over-testing and improving yield; all adults including women, adolescents and children accessing OPD will be screened for HIV risk with those at risk being offered HIV testing. In FY19Q1-Q2, 54.8% of all cases identified in OPD were males.
    - *Diagnostic testing* of patients who present with signs or symptoms suggestive of HIV. Refer to Table 4.1.1 above for detailed HTS and Linkage to Treatment Strategies modality deployment by SNUs.
- *Rapid Scale-up of Index Partner Testing:* To reach adult women through all newly identified men. Men enrolled in treatment in the last 24 months will also be prioritized for partner elicitation. Index client ART files in IDCC/ANC will use color coded flags for “needs elicitation,” “in progress,” and “complete.” Index cases will also be sourced from new cases identified among HIV positive men seeking and receiving treatment for TB and STI. Non-suppressed viral load registers will also be used as starting point for index testing of partners of men who are long-term HIV clinic clients

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found to have unsuppressed Viral load during routine testing. Adult men, who do not volunteer to bring their partners for index testing, will be offered self-testing kits. (Refer to Table 4.1.1 above)

- *HIVST*: To optimize case finding among adult women in facility settings, HIV self-test kits will be distributed to HIV adult men presenting at health facilities to distribute to their sex partners. Adult men, who do not volunteer to bring their partners for index testing, will be offered self-testing kits. (Refer to Table 4.1.1 above)

- *Targeting adult women through high yielding strategies (STI and TB):* STI and TB are among the highest yielding modalities for the PEPFAR/B PITC program with yields of 14% and 6% respectively.

    - *STI modality: D*uring FY19Q1-Q2, 61% of HIV positive cases identified through this modality were females reinforcing the value of this strategy for identifying women.

    - TB: Collaboration between facility HIV testing and TB/HIV implementing partners has significantly improved identification and HIV screening of presumptive TB patients. At most facilities, although twice as many women as men present to health facilities, only 37% of presumptive cases were women identified during FY19Q1-Q2. Based on lessons learned from Reboot, COP19 funds will support strengthening intensified TB screening and HIV testing among adult women. (Refer to Table 4.1.1 above)

4.1.2c Wellness Clinics

In COP 18 PEPFAR/B introduced community based wellness clinics accredited and licensed by MoHW to provide comprehensive ART services among others. Two of these clinics started operations during COP 18, while another two will commence operations in COP 19. This model has been a game changer for the Botswana response in places where these sites are operating by closing the Linkage to Treatment (LTT) gap, providing same day ART initiation, extended hours of operation including over the weekend. The wellness clinics are KP friendly and offer additional options especially to men and young people who do not want to utilize the traditional public health care facilities.

i) **HIV Self-Testing**

HIVST is an approach that will be used for expanding access to HTS especially among men and young people. Currently the Wellness clinics have started using HIVST modality, and in COP 19 this will be expanded to reach more clients. Linkage to HTS will be a critical activity following a positive HIVST. Both assisted and unassisted HIVST strategies will be emphasized during scale up to give clients options. Assisted strategy refers to when individuals who are self-testing for HIV receive an in-person demonstration from a trained provider during HIVST, with instructions on how to perform a self-test and how to interpret the self-test result. This assistance will be provided in addition to the manufacturer-supplied instructions for use and other materials found inside HIVST kits. Unassisted HIVST will be used as a secondary distribution of HIVST kits without additional instruction or assistance. It is expected that self-testing will augment other modalities and contribute substantially to case finding.

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4.1.2d Case Finding among Key Populations:

The BBSS II (2017) revealed that the proportion of MSM who have ever tested has increased significantly since 2012 (76.2% vs 91.8%) and this trend is seen across districts. Highest testing rates are highest in Gaborone and Chobe and fairly similar in Francistown, Palapye and Maun. Those who have never tested are mostly afraid of learning that they are HIV positive. About 76% tested in the last 12 months compared to 80% in 2012. Most of them tested HIV negative. Among Female Sex Workers, 92.9% had ever been tested for HIV, compared to 88.1% in 2012 BBSS. Just over half had an HIV test in the last year, which was similar to 2012. Access to treatment for those who knew their status improved drastically from 2012 BBSS from 25% to 88% in 2017 BBSS II. Knowing one's HIV status was an entry point to treatment. Among FSWs, HIV prevalence steadily increases by age group. Declines between 2012 and 2017 were seen most noticeably in the younger age groups. Among MSMs HIV prevalence steadily increases by age group and doubles in the 40-49 age group. PEPFAR/B's case finding strategy therefore focuses on an improved HIV screening tool that is able to identify the FSWs at highest risk.

To enhance case finding for FSW and MSM PEPFAR Botswana has revised the mobilization and recruitment strategy for individuals to be offered HIV testing Services. The program will prioritize high-yielding case finding strategies from the community and the facility. These strategies include:

a) Use of high risk screening tools
b) Conduct strategic network mapping to identify untested/unlinked KPs
c) Use incentivized approach for peer outreach workers
d) Use peer navigation and expert clients. Trained peer navigators most of whom are living with HIV, serve as role models and provide guidance in facility navigation as well as linkage to other appropriate services.

PEPFAR/B's KP program will also use risk network referrals and voluntary partner referrals (VPR). Specifically the program will use Voluntary Partner Referrals based on World Health Organization's partner notification model to:

1) Expand use and frequency of Enhanced Peer Outreach Approach (EPOA) that engages individuals at high risk of or living with HIV to recruit members of their social and risk network for HTC. EPOA includes performance-based incentives that provide peers with increasing benefits in return for achieving measurable service benchmarks and coupons to track referrals, testing and linkage to treatment.
2) Index testing that rides on EPOA. Engagement of KP members that are newly diagnosed with HIV to identify their sexual partners and members of their networks.
3) Use HIV Self-Testing for KPs and their clients. This will overcome stigma and discrimination and fear of loss of confidentiality.
4) Introduce test for triage among the KP community using self-test kits. KP Community providers will conduct a single rapid diagnostic test. KPs with a reactive test will be linked immediately to a facility for further HIV testing and treatment. Those with non-reactive results and recommended for enrolment into PrEP and other prevention services.

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5) Employ ICT to engage and recruit the online population of KP especially those visiting match-making and dating sites. Online outreach makes the program relevant to young and urban populations.
6) Link eligible HIV negative FSW in Gaborone and Kweneng East to DREAMS project. The testing under DREAMS will be tracked differently.

In terms of HTS modalities, the PEPFAR/B KP program will use HTS testing strategies that have been documented to be KP relevant and high yielding. The following modalities will be used: facility based VCT at Wellness Centers; index testing at both facility and community; and mobile testing as outreach at community level. This will be complemented by on online platforms where mostly MSM wishing to remain anonymous will book an appointment with a choice of services either at TWC or at a private practitioner. This approach has proved popular among MSM PEPFAR projects in Kenya and India. In COP19, priority has been given to targeted mobile outreach strategies at hot spots. Index testing among regular partners of FSW and MSM will be rolled out. The use of HIV self-testing will enhance the reach of index testing to KP partners who still wish to remain anonymous. At the Wellness Centers facilities, FSWs who present at STI and reproductive health sections will be screened. Partners and children of FSWs will be referred for HIV testing/self-testing and those who test positive will be fast tracked into treatment. Biological children of KPs will be elicited and referred to OVC partner for continued support.

LINKAGES Botswana program data was analyzed further and case finding needs were tailored to the local epidemic and the key populations' context in those areas.

1) Chobe: This site has reported low case-finding currently at 6%, which is attributed to high treatment coverage rate among key populations. The strategy in Chobe is to expand HTS services to "hard-to-reach" areas especially the safaris and hotels.
2) Ngami: The site has a 13% case-finding which is one of the highest of case finding in the entire program. Reboot activities which are already ongoing have started addressing the low linkage rate currently at 73%. This site will also begin expand services to "hard-to-reach" areas- safaris areas.
3) Francistown: There is increase of risk behaviors reported this includes low rate of condom use at last sex at 46.8% and also increase anal sex and increase in STIs (syphilis). BBSS II reported a drop in prevalence from 53.5% to 37%. There is therefore need to enhance index testing in Francistown. Non-citizen FSWs who were earlier left out in the treatment program will be reached through the reboot approach and linked into treatment.
4) Gaborone: Gaborone has a high numbers of KP already on treatment. Most of the MSM are also engaged with either work of school. HIV self-testing will be enhanced in Gaborone. Use of social media will also be accelerated in Gaborone. Non-citizen KP not on treatment will be identified through reboot activities and linked into treatment.

4.1.3 Linkage to treatment

Under the Reboot, linkage to treatment involved both retrospective and prospective clients. For retrospective clients this involved tracking and tracing known positives never on treatment and linking

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them, through phone calls, counseling, etc. to ARVs. For prospective clients the main activities revolved around addressing the leaking cascade between testing and treatment and preventing or relinking LTFU.

Reboot facility-based activities around linkage to treatment were modified to remove facility linkage officers and instead ensure direct handing over of newly identified HIV positive clients by the facility testing partner to a NP or doctor for immediate ART initiation. In addition, a 1:1 matching of tester and NP was implemented in most of the 41 reboot sites. An on-call NP was introduced to cover facilities with extended hours and weekend HIV testing. These strategies ensure that clients are not lost between the testing and treatment points. To optimize LTT, the facility based activities around linkage to treatment involves the Expert Clients (EC), "Treat All Ambassadors" and Community Healthcare Workers (CHWs) actively following up by phone, counselling and facilitating linkage of newly identified patients at the facility that were not linked to treatment within three days.

Community IPs also actively track and trace retrospective (legacy) clients who have been previously diagnosed HIV positive but are not on treatment. From the lessons learned during Reboot, having a NP always available for ART services in 24-hour facilities, during extended hours and during weekends improved linkage to treatment, improved facility-community interface and is crucial to improving linkage to treatment. Currently there have been challenges with handing over clients at three days, with only around 18% of the eligible clients handed to date. Going forward, PEPFAR/B will work to close the linkage gap through ensuring active handover of patient from the facility to the community for follow up. The challenges faced with tracing the retrospective clients include incomplete documentation of patient information, incomplete locator information as well as changing of phone numbers or contacts.

4.1.3a Treatment Initiation

COP18 Reboot implementation has demonstrated good alignment of testing and ART services and facility-community interface in the continuum of patient care. The overall LTT during Reboot improved from 62% to 76% while LTT for citizen only improved from 71% to 86% in the reboot sites. Same-Day initiation improved from 23% to 53% while Fast-Track increased from 49% to 71% (Table 4.1.7).

These improvements were also attributed to the deployment of nurse prescribers by the IP to augment GoB HRH at the sites and the mobilization of fast-track champions in GoB facilities to implement same day initiations. Several changes at the larger hospitals (including the two referral hospitals – Princess Marina in Gaborone and Nyangabgwe in Francistown) helped improve LTT which traditionally have very low or initiation rates. The practice of "Start and Transfer" with good participation from nurse prescribers and clinicians has helped improve LTT rates at the big hospitals. NP and clinicians were recruited to facilitate

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Table 4.1.7 Linkage to treatment at 41 Reboot sites

Site	Total to be LTT	Citizens to be LTT	Same day LTT rate	Fast track rate	Overall LTT rate	Citizen LTT rate	Total to be LTT	Citizens to be LTT	Same day LTT rate	Fast track rate	Overall LTT rate	Citizen LTT rate
Air Strip Clinic	31	30	29%	77%	87%	90%	26	26	77%	96%	96%	96%
Area W Clinic	72	62	42%	67%	75%	87%	47	42	64%	77%	83%	93%
Bamalete Lutheran Hospital	36	27	17%	39%	58%	78%	23	19	39%	61%	70%	84%
Block 8 / Kgatelopele Clinic	31	26	45%	52%	65%	77%	28	26	46%	71%	82%	88%
Bontleng Clinic	41	40	29%	61%	71%	73%	30	30	63%	83%	90%	90%
Borakalalo Clinic	25	25	12%	68%	92%	92%	8	8	88%	88%	100%	100%
Borolong Clinic	26	21	4%	38%	65%	81%	16	16	50%	88%	88%	81%
Boseja 2 Clinic (Kgatleng)	21	20	14%	43%	57%	60%	30	29	63%	67%	80%	83%
Botswelelo Clinic	50	45	0%	38%	84%	93%	11	9	64%	64%	73%	89%
Broadhurst Clinic III (Tsholofelo Clin	47	46	23%	77%	85%	87%	37	34	73%	84%	89%	97%
Broadhurst II Clinic	26	25	42%	54%	65%	68%	13	13	77%	85%	92%	92%
Broadhurst Traditional Area Clinic	20	20	45%	85%	85%	85%	8	8	75%	75%	88%	88%
Deborah Retief Memorial Hospital	49	33	0%	18%	29%	42%	27	24	32%	56%	70%	79%
Extension 3 Clinic	32	32	56%	84%	84%	84%	23	23	74%	87%	96%	96%
Extension II Clinic	30	27	13%	57%	73%	81%	39	30	49%	59%	62%	80%
Gaborone West Clinic	54	50	17%	63%	81%	88%	36	34	72%	83%	83%	85%
Gerald Estate Clinic	24	23	54%	83%	83%	87%	18	16	56%	67%	78%	88%
Jubilee Clinic	27	27	22%	67%	85%	85%	29	28	59%	83%	83%	82%
Julia Molefe (Block 9) Clinic	76	64	29%	53%	61%	72%	58	42	53%	62%	66%	88%
Kadimo Clinic	25	25	28%	60%	76%	76%	19	19	68%	79%	84%	84%
Kanye Clinic	23	21	43%	70%	83%	90%	15	15	93%	100%	100%	100%
Kanye SDA Hospital	78	76	19%	37%	60%	62%	34	30	32%	53%	74%	80%
Kediretswe Clinic	64	58	34%	58%	66%	72%	54	52	78%	85%	89%	92%
Lesirane Clinic	115	69	31%	48%	54%	90%	89	65	48%	63%	64%	85%
Mahalapye District Hospital	60	53	18%	40%	52%	58%	51	50	59%	86%	92%	94%
Mahlaku Lekganyane Clinic	31	28	32%	55%	71%	79%	22	21	64%	77%	91%	95%
Masego Clinic	45	43	22%	73%	84%	88%	33	31	58%	85%	91%	97%
Mogoditshane Clinic	55	47	53%	60%	76%	89%	39	31	74%	74%	74%	94%
Moshupa Council Clinic	40	38	3%	20%	38%	39%	12	11	50%	83%	83%	91%
Nkoyaphiri Clinic	79	68	39%	56%	66%	76%	64	53	53%	67%	72%	87%
Nyangabgwe Referral Hospital	88	75	17%	28%	53%	63%	57	43	19%	53%	56%	72%
Old Naledi Clinic	42	41	21%	60%	81%	83%	35	34	66%	83%	86%	88%
Palapye Primary Hospital	86	77	9%	44%	57%	64%	50	46	42%	76%	82%	89%
Phase 2 Clinic	28	26	50%	68%	71%	77%	23	20	61%	65%	74%	85%
Princess Marina Hospital	186	145	8%	16%	28%	36%	144	121	31%	57%	64%	76%
Scottish Livingstone Hospital	48	47	0%	17%	33%	34%	42	40	40%	64%	71%	75%
Sekgoma Memorial Hospital	35	29	9%	14%	37%	45%	19	17	47%	53%	58%	65%
Serowe Clinic	23	21	0%	61%	74%	81%	27	27	74%	89%	89%	89%
Tonota Clinic	63	60	35%	75%	84%	88%	41	34	39%	61%	68%	82%
Tutume Primary Hospital	40	36	13%	48%	60%	67%	23	22	52%	65%	78%	82%
Village (Ext 15) Clinic	25	23	44%	60%	72%	78%	16	13	44%	56%	63%	77%
Total	1997	1749	23%	49%	62%	71%	1416	1252	53%	71%	76%	86%

ART initiation at OPD and in the wards at the hospitals. Clinicians joined the hospital clinical team ward rounds and facilitated the initiation of patients on admission before they were discharged from the hospital. Under the "Start and Transfer" strategy, patients are registered and initiated on ART in the hospital and then transferred to continue treatment services at facilities of their choosing or those closer to their homes. The hospital continues to follow up with the client to ensure that he or she has reached the preferred ART site.

Joint site support visits by MoHW and PEPFAR/B are ongoing to address facility specific challenges to ART initiations at the major hospitals. These joint visits include PEPFAR/B and MoHW top leadership to address management related issues in the two referral hospitals. PEPFAR/B plans to expand the joint PEPFAR/B-GoB site visits to other districts and hospitals through COP18 implementation, and ensure that this is fully scaled up by COP19 implementation. COP19 support will additionally include scaling-up of the best practices/lessons learned from Reboot to other high volume facilities across the country.

Using the case management approach through the use of expert clients (ECs), social workers, case managers, ambassadors and CHWs, PEPFAR/B continues to address the individual-level barriers that hinders patients from linking to treatment such as low treatment literacy, lack of awareness of Undetectable=Untransmittable (U=U), stigma and discrimination, fear of disclosure, fear of medication side effects, fear of loss of masculinity, fear of lifelong treatment, fear of medicine's interaction with alcohol, trust in alternative healthcare. To address these issues, PEPFAR/B will implement strategies that include offering integrated one-stop-shop services through the wellness clinics, expert-clients assisted disclosure, client literacy and CHWs escorting clients to health facilities on a case by case basis.

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Furthermore, PEPFAR/B communications program will continue to actively roll out "Treat All" messaging and continue to use the USG produced, "Have It All: The Story of the Treat All Program in Botswana" documentary to spread treat all messaging and to break the stigma associated with HIV treatment.

In COP19, PEPFAR/B will replicate the reboot model in 53 supported sites and support the provision of additional NP for extended hours and weekend ART service in facilities with overlapping testing partner to ensure that patients who have a positive HIV test result have access to immediate ART initiation. Also PEPFAR/B will build GoB capacity to optimize linkage to treatment through integration of ART service at OPD, capacitating GoB nurse prescriber to serve as "Fast Track Champions," ART initiation on non-ART clinics days, use of 30 day starter packs as a means to operationalize the Same-Day and Fast-Track minimum requirement already adopted by GoB. GoB/PEPFAR MPR TWG will actively engage in implementation and monitoring of the MPR relating to ART initiation.

In COP 18 PEPFAR/B introduced a differentiated service delivery approach through the Tebelopele Wellness Center. Treatment services are provided in a one stop shop platform (service integration) that covers the continuum of care focusing more on priority populations to close treatment initiation gap. These services are accessible through weekend and extended hours of operation and are particularly attractive to men and young people. Currently 70% of all the clients on treatment at the wellness clinics are either men or AGYW. Though HTS was halted in FY 19 Q2, the number of clients initiated on ART through the wellness clinics increased, an indication that communities are increasingly appreciating these new differentiated service delivery points. In COP 19, PEPFAR/B will expand promotional activities such as presentations at radio and television stations, use of social media, video clips as well as engaging expert clients and Treat All ambassadors to use their experience towards mobilizing PLHIV to link and remain on treatment.

To strengthen the wellness clinics, PEPFAR/B will implement mobile clinic outreaches to take treatment services to the hard to reach locations and populations, especially men. All stable ART patients at wellness sites will be given six month clinical consultations appointments and three months of ART refill, with a possible transition to six month MMD subject to the MoHW guidance.

Adult men

In FY18 Q1, a PEPFAR/B partner began piloting integrated ART services in existing MoHW facility-associated outreach "Mobile Stop" clinics in collaboration with the DHMT in Mahalapye. Through the use of a mobile unit, this strategy has allowed the partner to reach more distant rural areas that have a predominantly high number of men (herd boys and farm workers) with HIV services that include ART initiation, ARV dispensing as well as blood sample collection for VL test. PEPFAR/B will work with DHMTs to expand the existing GoB facility Mobile Outreach service to include ART service as a strategy for reaching men in hard to reach areas (herd boys and farm workers). COP19 funds will support expansion of this approach through capacity building initiatives. In COP19, case management approach using the Expert client, Case manager and Social worker will be used to address possible patient related barrier to immediate treatment initiation. Through the PEPFAR/B FBO initiative, engagement of champions in faith will be used to promote and strengthen linkage to treatment as well as retention in care for men.

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Adult Women

In COP18, PEPFAR/B continued to use Family Planning (FP) as in COP17 as an entry point to both HIV testing and treatment services for adult women targeting especially women of child bearing age (20-24, 25-29 and 30-34). Intensified Treat All messaging intended to reach older women especially those beyond the child-bearing age who may have missed the PMTCT program or possibly got infected in the post-menopausal period. Treatment literacy is particularly important for this age group of adult women (40-49 and 50+ age bands) because they will not receive ART services through PMTCT similar to child bearing age women. In COP19, PEPFAR/B will continue to target women who were previously on PMTCT Options A and B,prior to B+ option, with Treat All messaging emphasizing the importance of early treatment initiation and treatment as prevention. COP19 will include scaling-up this best practices/lesson learned from reboot to other high volume facilities, especially referral hospitals.

Treating AGYW

Extended hours for treatment initiation targeting adolescents will be scaled up through COP19 support. Even though not specific for AGYW, the adolescent transition to adult care strategy described under the section on children will greatly support AGYW during COP19 implementation. TA through site visit and mentoring will be provided to facility providers to provide youth friendly services to AGYW.

4.1.3B Treatment initiation of KP

At the end of FY 18, PEPFAR/B reviewed the data of all members of key population that had been tested HIV positive from FY16 to FY18. The exercise was led by Peer Outreach workers and it was known as Peer Network (PN) Surge. This was aimed at ensuring that all KP who were living with HIV were linked on treatment and were virally suppressed.

During the reboot, the KP partner was given a list of 300 KP legacy retrospective clients with unique identifiers to follow. Of these, 252 (85%) were found to be active on treatment, only 28 (9%) were uncontactable and 14 (5%) declined/refused treatment. Eighty-one (81) of the 300 KPs were currently on treatment from FY18 (TX_CURR, FY18) and of these 38 (47%), were eligible for VL testing. Out of the 38, 100% were tracked and returned for bleeding for VL testing. Partner reboot activities for prospective clients led to a 211% increase in initiations at the selected reboot sites, though some sites had fewer initiations than Q1/baseline, KPs initiated were fast-tracked. These sites account for 65% (71/110) of all initiations in Q2.

Different KP sites have different reboot challenges and therefore reboot solutions and interventions are customized for each hotspot site:

Ngamiland District: The public health facilities account for 67% (14/21) of all KP initiations in Maun/Ngamiland. The district has low linkage of 73% due to difficulties in the implementation of same-day/fast-track by the public health facilities in the district which have been attributed to staff shortage. The immediate reboot remedial measures include the following:-

- Identified KP model clinic (Matshwane Clinic, Boseja and Maun Clinic)

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- Identified a KP focal nurse
- Same day initiations and Fast track and active escorted referrals from community to facility by peer navigators
- Provided clients with transport during reboot (Pick and drop with an unbranded vehicle)
- Hired an extra Lay Counsellor

Chobe District: During the key population cascade analysis that took place in November 2017, the multi-agency team visited the DHMT and toured the lab. The team identified challenges with VL monitoring (frequent stock-outs of reagents) lab machines with low throughput and there were lab staffing issues. During reboot interventions to address this and also first tracking issues were discussed with the DHMT. The following actions have been put in place as remedial measures.

- Identified three KP model clinics, though low volume (Kazungula HP, Kasane HP, Weigh-bridge Clinic)
- Conducted Facility assessment on KP Friendliness and provided TA
- Conducted KP Competency training for HIV Care services for nurses in the district
- Provided active escorted referrals from Community to Facility by Peer Navigators for ART initiation and Viral Load Testing
- Consultative meeting with DHMT to enhance provision of KP services in the district (VL coverage, establishing weigh-bridge clinic as KP clinic, services to hard-to-reach area)
- Hired an extra Lay Counsellor

Selebi-Phikwe and Palapye: There was no clinical partner for key populations in these districts. Public Health Facilities account for 83% (15/18) of all initiations in the district. The improvement of the client handover to public health facilities using model clinics where other facilities could bench mark was imperative. There was also need to effectively engage key population enhance community support groups to provide community refills/MMD and also follow-up of key population living with HIV and AIDS to increase retention rates. Specifically the following interventions will be put in place to address reboot issues of client fast tracking and ensuring VL coverage is increased in Selebi-Phikwe.

- Identified KP Model Clinic (Kagiso Clinic, Tapologo, Sesame, Botshabelo)
- Identified KP Focal Nurse in each clinic to facilitate fast-tracking of KPs
- Fast track and active escorted referrals from Community to Facility by Peer Navigators
- Tracking of clients for Viral Load testing during the reboot

Serowe/Palapye: The following interventions will be implemented:

- Identify KP model clinics (Lotsane, Serowe Clinic), accounting for 6/11 initiation (55%) in the district during reboot
- Identify KP Focal Nurse at each facilities
- Fast track and actively escort referrals from Community to Facility by Peer Navigators
- Conduct KP Competency training for HIV Care services for 2 nurses in the district

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Francistown: Only 87% of FSW who tested HIV positive in the district were initiated into treatment. To address the treatment initiation gap among FSW the following reboot remedial measures have been put in place.

- Hired additional staff (lay counsellors)
- Identified KP model clinic (Area W, Botshelo Clinic) and KP focal nurse
- Strengthened referral mechanisms between community and facility with clear processes for fast track initiations.
- Provided same-day initiations during outreach and at the facility.
- Provided active escorted referrals from community to facility by Peer Navigators for ART initiation and viral load testing.

Gaborone has the highest number of FSWs in Botswana. The Tebelopele Wellness Center (TWC) accounted for 13% of all initiations during reboot and it increased same-day initiations from five in Q1 to 23 in Q2. This accounted for 64% of all same-day initiations across the LINKAGES reboot sites. TWC provided same-day initiations during outreach and at the facility. Gaborone TWC was identified as the PEPFAR reboot site to monitor same-day and fast track initiations – 83% of KPs initiated at this site during the reboot were initiated within 7 days.

To strengthen TWC and enhance reboot results the following additional actions were undertaken.

- Hired additional staff (nurses and lay counsellors)
- Provided active escorted referrals from Community to Facility by Peer Navigators for ART initiation and Viral Load Testing.
- Strengthened referral mechanisms between community and facility with clear processes for fast track initiations.

Table 4.1.8 Initiation rate at 14 KP Reboot Sites (Citizens only)

	Current	Previous	% change	% of Total
Total Initiation (citizens)	53	17	211%	
Same-Day initiations	23	n/a	100%	43%
2-7 Day initiations	10	n/a	100%	19%
8-30 Day	14	n/a	100%	26%
More than 30 days	6	n/a	100%	11%

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62% of KPs were fast tracked (same day or within 7 days), across reboot sites. Only 38% were initiated after 7 days. LINKAGES continues support districts to increase same day initiations and fast tracking

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4.1.4 Retention

4.1.4a Retaining adult men and women on ART and keeping them virologically suppressed

To reach epidemic control, all PLHIV must be identified, linked immediately to treatment, and retained on treatment with viral suppression. If PLHIV are not retained in care, they are at risk of continued transmission. During Reboot, the routinizing of the appointment system was strengthened with clients who missed appointment being contacted by phone by a designated person (HCA or EC) who rescheduled clinic appointment. Those that could not be contacted by phone are traced at the community by the community partner. Successfully traced clients in the community are linked back to facility/treatment. List of defaulters and LTFU were also generated from the facility appointment register, and from the treatment database. The generated list was validated using IPMS to establish the status of the client. Those patients found to be active in the facility, transferred out or dead are updated in the facility register with the new status or outcome of the tracking. List of patients unable to be contacted by phone or refused treatment are given to a community IP for follow up. In places without a community IP, the EC, facility HCA or HEA undertake the tracing in the community. The defaulters and LTFUs returning to care receive adherence counselling support through the NP, social worker, or EC. Those requiring more support are referred to Case management support by the case manager and social worker who work closely with the patient to address psychosocial issues for dropping out of care. The EC also serves as the adherence buddy, an extra support system for patients returning to care.

Table 4.1.9 Improve Retention Following Reboot

Baseline Retention FY19 Q1

District	<15		15-19		20-24		25-29		30-34		35-39		40-44		45-49		50+	
	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male
Francistown	100%	88%	98%	92%	95%	92%	96%	98%	98%	94%	96%	97%	97%	97%	96%	92%	95%	96%
Gaborone	100%	N/A	89%	100%	91%	89%	92%	91%	94%	93%	96%	91%	97%	93%	94%	93%	94%	93%
Goodhope	100%	100%	83%	100%	79%	89%	81%	67%	86%	60%	83%	78%	92%	86%	89%	86%	88%	75%
Kgatleng	100%	75%	76%	100%	88%	80%	87%	83%	90%	89%	92%	91%	89%	91%	96%	85%	91%	91%
Kweneng East	100%	100%	93%	100%	89%	100%	98%	89%	95%	95%	96%	98%	94%	97%	90%	92%	94%	93%
Mahalapye	100%	100%	91%	100%	90%	82%	88%	88%	98%	92%	96%	90%	100%	92%	100%	88%	97%	92%
Moshupa	N/A	N/A	100%	N/A	63%	100%	100%	67%	92%	88%	100%	100%	100%	92%	80%	100%	89%	71%
North East	100%	N/A	100%	100%	86%	100%	89%	100%	100%	80%	83%	100%	67%	100%	100%	100%	83%	67%
Palapye	100%	100%	93%	100%	92%	100%	99%	96%	96%	97%	99%	100%	95%	95%	93%	85%	96%	93%
Serowe	100%	80%	100%	100%	86%	93%	92%	96%	91%	94%	94%	97%	97%	95%	93%	100%	92%	94%
South East	100%	100%	17%	0%	68%	80%	70%	50%	70%	72%	70%	52%	85%	72%	78%	69%	71%	78%
Southern	100%	N/A	95%	100%	86%	73%	90%	73%	95%	71%	86%	91%	91%	86%	86%	92%	89%	86%
Tutume	90%	88%	88%	100%	90%	92%	87%	80%	92%	98%	98%	93%	97%	97%	91%	85%	98%	91%
Overall	98%	91%	89%	95%	90%	89%	92%	89%	94%	91%	95%	92%	95%	93%	92%	90%	93%	91%

Baseline retention is **92.8%**

Updated Retention FY 19 Q2

District	<1 Female	1-4 Female	5-9 Female	10-14 Female	15-19 Female	20-24 Female	25-29 Female	30-34 female	35-39 female	40-44 female	40-45 female	50+ Female	<1 male	1-4 male	5-9 male	10-14 male	15-19 male	20-24 male	25-29 Male	30-34 Male	35-39 Male	40-44 male	45-49 Male	50+ Male
Francistown	100%	100%	100%	100%	99%	99%	99%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	99%	99%	100%	99%	100%	100%	100%
Gaborone			100%	100%	99%	99%	99%	99%	100%	100%	100%	100%			100%	100%	96%	99%	98%	99%	99%	99%	100%	100%
Goodhope		100%	100%	100%	95%	100%	100%	100%	100%	100%	100%	100%		100%	100%	100%	100%	100%	100%	99%	100%	100%	100%	99%
Kgatleng	100%	100%	100%	100%	97%	98%	98%	99%	100%	100%	100%	100%		100%	100%	100%	100%	99%	97%	99%	99%	99%	100%	100%
Kweneng East	100%	100%	100%	100%	100%	99%	99%	100%	100%	100%	100%	100%		100%	100%	98%	99%	99%	99%	99%	99%	99%	100%	100%
Mahalapye	100%	100%	100%	100%	99%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	99%	98%	100%	100%	100%	100%	100%
Moshupa			100%	100%	100%	100%	100%	100%	100%	100%	100%	100%		100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
North East		100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%			100%		100%	100%	100%	100%	100%	100%	100%	100%
Palapye		100%	100%	100%	99%	94%	97%	98%	98%	99%	99%	97%	100%	100%	83%	92%	100%	97%	98%	99%	96%	99%	98%	96%
Serowe	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
South East		100%	100%	100%	97%	97%	99%	100%	99%	99%	100%	100%		100%	100%	100%	97%	97%	93%	98%	99%	99%	99%	99%
Southern	100%	100%	100%	100%	97%	91%	96%	98%	99%	99%	99%	99%		80%	100%	100%	100%	92%	93%	96%	98%	98%	99%	99%
Tutume	100%	86%	100%	100%	99%	100%	100%	99%	100%	100%	100%	100%	100%	100%	100%	100%	98%	96%	100%	99%	100%	99%	99%	99%

Improved Retention – **99%**

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COP18 Reboot data analysis show an improvement in retention from 93% in FY19Q1 to 99% in FY19Q2 (Table 4.1.2). PEPFAR/B will continue to scale up technical assistance and direct service delivery to ensure good adherence to treatment, support LTFU and defaulter management SOPs which form part of the mentorship program for HCWs. The scale-up of client literacy programs will be continued at both the facility and community levels to emphasize adherence. Using the BCPP experience, support is provided to facility staff to manage appointments and generate LTFU lists, which is then handed over to community partners to assist with tracing and linking patients back to the facility.

In COP19, a case management approach using expert clients, ambassadors, CHWs, case managers and social workers will be used to support retention on treatment by providing psycho-social support, tracking and tracing, and continuous adherence support. Compliance to the use of registers for missed appointments and LTFU as well as peer support groups to support adherence to treatment for all age and sex bands will be enhanced. The use of differentiated service delivery, MMD and community ART refills, will be a strategy that will be fully implemented in COP19 to improve retention. Currently PEPFAR/B has partnered with Gaborone DHMT who identified an improvement aim of reducing multiple visits and multiple consultations of patients on ART in the Old Naledi clinic through community ARV refill by trained CHWs and HEAs. The pharmacist prepack refill medication and hand them over to a trained CHW or HEA to be delivered at home or workplace. The patients selected for this model are stable on treatment for a period of 12 months, not missed refills for 12 months, have two valid viral loads spaced by 6 months and no opportunistic infections. PEPFAR/B will ensure a rapid expansion of community ART refill models to at least two more sites by end of FY 19, guided by MoHW. In COP 19 PEPFAR/B, in partnership with the MoHW, will develop an objective based Framework to guide facilities and districts in the choice and implementation of relevant DSDs, for implementation sites. The DHMTS of the selected sites will be engaged and orientated on DSD to facilitate selection of implementation sites using quality improvement methodologies.

To support retention, PEPFAR/B will strengthen facility-community ties through the use of HEA to facilitate community tracking and tracing of clients. The National Strategic Framework (NSF III, 2018–2023) identifies inadequate facility-community collaboration in the provision of HIV services as one of the gaps impeding achievement of the national HIV response. It proposes a number of strategies, including maximizing the potential of existing staff mix to deliver services. The HEAs are engaged to perform a facility-to-community role of tracing clients who miss clinical services with 80% of their time allocated to achieve this. There exists an opportunity to increase retention with additional HEA training on retention and viral load tracking activities to ensure continuity of care and minimize risk of patient LTFU. Additionally, given the current practice of using this cadre during mobile ART outreach services, the HEA expanded roles could also be beneficial to providing tracing roles during these visits. Their contribution to tracing efforts was observed during the Reboot period, working closely with expert clients in the community care program districts where clients could not be traced through the phone.

Meanwhile, PEPFAR/B community programs continue to successfully support health facilities with retention of patients in care and treatment by tracing clients who had missed appoitments, defaulted, or were LTFU. Though tracking of LTFU is time consuming because it usually requires multiple attempts, it is a critical community service as it increases retention in care and also provides facilities with feedback

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needed to update client records of the number of patients who are actually not on treatment and the outcomes of LTFU, including transfers to other clinics, death, unable to locate, not traced, or reinitiated. In COP 19, PEPFAR/B will continue to implement a comprehensive set of community-based care and treatment retention interventions tailored to the recurring needs of PLHIV.

Table 4.1.10 Retaining adult men and women on ART and keeping them virologically suppressed

Retention Strategies by Population and age bands		
Age	**Adult Male**	**Adult Female**
25-34 35-45	• Use of social clubs for peer support • Expert Client • Case Manager • PHDP minimum package • Support Groups • Integration of ART in Mobile stop • Use of Faith based leaders to target men in churches	• Integrating ART with Family planning services • Peer support and Expert Clients • Case Manager • PHDP minimum package • Support Groups • Use of Faith based leaders to target women in churches
50+	• Integrate ART services with other health services e.g. Hypertension and Diabetes Mellitus • Use of Faith based leaders to target men in churches	• Track LTFU after Option A and B, motivate to keep in care through integrated services • Use of Faith based leaders to target women in churches

Retaining AGYW on treatment and keeping them virologically suppressed

In COP19, PEPFAR/B will continue to scale up treatment literacy efforts for AGYW, including strengthening teen clubs, using social media platforms, SMS reminders for medication and viral load and clinic schedules, integrating ART with family planning. Existing youth friendly services at facility will be strengthened to continue to deliver the minimum package for PHDP. In COP19, PEPFAR/B will support the implementation of the adolescent transition to adult care strategy. Health care workers both facility and community based will be trained on this strategy.

4.1.5 Viral Load Coverage & suppression

To address the challenge with viral load, VL champions and facility designated staff (nurses and HCAs) generate list of patients without a recent VL. IPMS was checked and VL result extracted if available with subsequent updated of the patient record. Patients without a recent VL result according to the National ART treatment guideline were contacted by phone and a bleeding appointment schedule for those that were reached. Patients not reachable by phone are referred to the community partners for follow up. During Reboot, expert clients are used for demand creation at the facility through health talks and support bleeding appointment for patients. Also, staffs were trained on IPMS for sample ordering, result entry. Reboot report shows a VL coverage improvement from 83% to 96% and a VL suppression of 93% (Figure 4.1.2). The challenges associated with virological coverage identified during Reboot are being addressed and best practices identified are implemented across support districts. Reboot activities to improve VL

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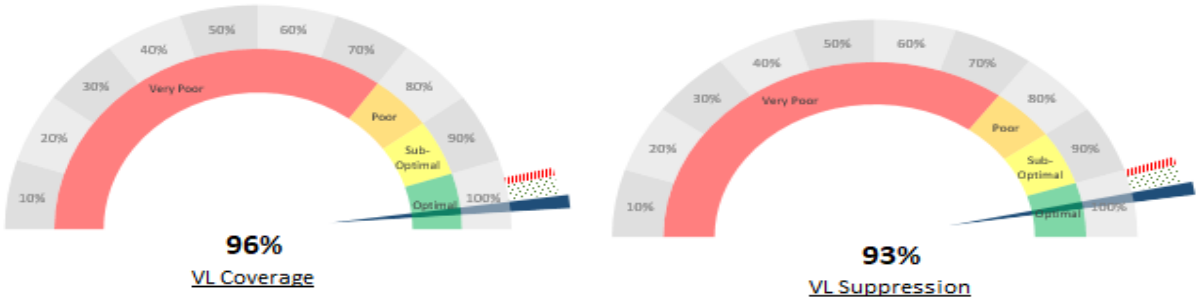
coverage included accessing data centrally from the Lab Management Information System (LMIS), generating line lists of clients without a VL, identifying point persons to call clients for bleeding and for establishing VL appointment systems at site. Both laboratory capacity and patient factors are addressed to close the access gap to ensure optimized VL suppression for all populations. The wellness clinics will support PEPFAR/B goal of attaining a high VL coverage and suppression through the use of POC VL.

Figure 4.1.2 Improved VL Coverage and Suppression Following Reboot



4.1.6 TB/HIV services

In Botswana, despite the provision of free ART to citizens and access to health services by a very high proportion of all residents, the estimated annual incidence of TB at 300/100,000 and TB/HIV co-infection at 50.3% are among the highest in the world. In the past year (FY18) among 2,527 TB patients identified, 2,515 (99.5%) knew their HIV status and 1,386/1462 (95%) co-infected patients were initiated on ART in PEPFAR/B supported districts. Though high ART coverage is being achieved among identified TB/HIV patients, the following major gaps remain in Botswana hence the need for more effort to control the HIV and TB epidemic:

1. Both TB and TB/HIV co-infection rates are unacceptably high.
2. There is loss of patients between TB diagnosis and registration to TB treatment; in FY19 the loss of patients has remarkably reduced and this effort need to continue.
3. TB screening and HIV testing among presumptive TB is not optimized as yet; this is especially evident among male age group 25 and above.
4. Non-citizens TB patients are not eligible for ART and failing to initiate non-citizens on ART compromises our effort to reach our 100% target.
5. TPT greatly reduces development of TB. The TPT policy issue has now resolved and we are at the planning phase to implementation and scale-up.

Also, more than four national TB drug resistance surveys conducted in Botswana showed an increase in new cases of Multi Drug Resistance (MDR-TB) from 0.2% in 1995 to 2.5 percent in 2008. The latest WHO estimates [Global TB report WHO, 2018] on MDR-TB for Botswana are 3.6% amongst new cases and 13%

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among re-treatment cases. WHO issued new guidance to improve treatment of MDR-TB and help countries close the gap associated with managing MDR-TB.

To continue to support the MoHW the following priorities are considered in TB/HIV control and prevention efforts.

- Strengthen the tracking system for patients diagnosed with TB but not registered for TB treatment and linkage of TB patients to HIV testing and ART if positive.
- Strengthen TB screening and testing presumptive TB patients for TB and HIV and initiate on ART if HIV positive; and initiate TPT if screened negative for TB symptoms and eligible for TPT. TB screening among HIV patients and HIV screening among presumptive TB patients will continue to be strengthened by coordinating implementing partners' activities so that yield increases and resources are utilized efficiently and effectively.
- Continue TPT Policy and guideline finalization and dissemination, initial implementation and nationwide scale-up of TPT.
- Advocate for policy change for non-citizens TB patients who are not eligible for ART and in the meantime coordinate access to ART through private practice.
- Continue training and strengthen supervision and mentoring activities and support the MoHW through technical assistance to achieve HIV epidemic control by capacitating health care workers, providing mentorship, supportive supervision and technical assistance in TB/HIV related activities at the national, district and health facilities.

At community Level PEPFAR/B will continue to support TB/HIV integrated activities:

- Provision of TPT through the community based Wellness Centers and also through Community ART/TPT refills. Community Health Workers who support ART distribution will also deliver both TPT for those patients who are co-infected.
- TPT Treatment Literacy and demand creation.
- Support health facilities to trace PLHIV that are not in community HIV care who are eligible for TPT and link them back for the service.
- Intensified case finding among PLHIV enrolled in community HIV care and among newly identified PLHIV through community HTS.
- HIV testing for TB presumptive and TB patients with unknown HIV status Tracing and linking back to facilities TB/HIV co-infected patients not on ART.
- Active referrals of presumptive TB clients to health facilities for diagnosis or sputum collection in the community.
- Support for community directly observed therapy short course (DOTS), including family supported DOTS.
- Treatment adherence counselling for both TB and HIV and tracing LTFU.
- Other community TB care interventions such as active case finding, contact tracing, infection control at household level, patient and community education on disease prevention and health promotion.

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4.1.7 COP19 Care and Treatment Programmatic Priorities

Care services for PLHIV

Care and treatment programming will focus on building strong linkages and coordination between facilities and communities to ensure a continuum of care for all health services along the three pillars of the clinical cascade. Adult care and treatment package of services will focus on retrospective LTT of legacy positives, same day and fast track LTT, retention in care, adherence as well as activities aimed at viral suppression and cognizant of specific needs at sites across age and sex bands. Cotrimoxazole prophylaxis will be provided to those with CD4 count <200 and TB/HIV co-infected for the duration of the treatment to prevent new opportunistic infections. Cryptococcal antigen screening which was introduced in COP17 with the 2016 Treatment guidelines will be continued and scaled up in COP19. Implementation of TPT will be scaled up in COP19.

Treatment services including routine clinic visits, ARVs, and care package

PEPFAR/B support for COP19 will be through targeted TA and DSD for care and treatment services at facility level and in the community as implemented during the Reboot period. This strategy focuses on facility to community, within GoBs existing structure, using HEA to implement this essential package of services. The capacity building through training and mentorship of health care workers around this service package will enhance quality client-centered care and sustainability beyond PEPFAR support. In COP 19, PEPFAR/B will support GoB to implement and monitor three month multi-month dispensing for stable patients across the country and the implementation of other differentiated service delivery initiatives.

4.2 Additional country-specific priorities listed in the planning level letter

Monitoring of the Implementation of the Minimum Program Requirements (MPRs)

The GoB's leadership since the PEPFAR annual planning meeting in Johannesburg last March has been particularly dedicated and productive. At the COP19 planning meeting Washington, Ambassador Birx said to the MoHW Permanent Secretary (PS) "You are moving at Warp Speed!" The MoHW has since established a high-level Health Leadership Forum and a supporting multi-stakeholder technical team to lead a process for identifying the roadblocks facing the adoption and implementation of each recommended policy, and develop a set of milestones and timeline to address these challenges. The U.S. Embassy Deputy Chief of Mission is a member of the forum. MoHW designated a point of contact (POC) at the deputy PS level to oversee the adoption and implementation of each MPR. This POC will be paired with point persons from the USG PEPFAR/B team. These POCs are tasked with setting timelines, tracking and reporting on implementation progress, and convening the right technical organizations for contribution.

The USG and other non-GoB partners, including other donors, the private sector, higher education institutions, PEPFAR implementing partners, and local civil society organizations are fully represented in the process.

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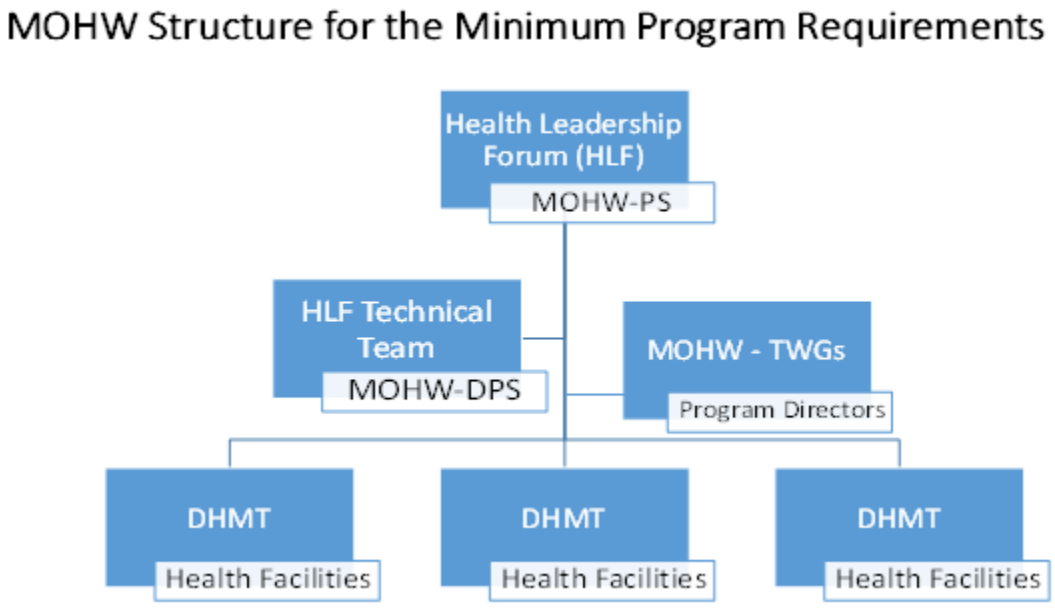
To ensure the sustainability of the MPRs – which is fully adopted, owned, and carried out with fidelity and scale by GoB beyond COP19 – the USG intends to use a combination of the newly created and existing MoHW structures to support, monitor, and report on the implementation of the MPRs. The graph below shows the key actors and levels of intervention in the monitoring of the MPRs.



The HLF monitors the implementation of the MPRs through periodic (proposed monthly) progress reports by the DPS who is supported by the HLF Technical Team and the chairs of the MoHW-TWGs. These progress reports are primarily based on the milestones and timelines approved by HLF.

The TWGs, which also include the POCs for the MPRs, work with the DPS to inform the formulation of relevant policy directives (i.e. the Savingrams) and support the health districts (DHMTs) in translating these directives into concrete and reportable programmatic activities with set targets at the health facility level. There are national (MoHW-led) TWGs on HIV Testing, PrEP, VMMC, Linkage and Treatment, TB/HIV, M&E, DREAMS, ARV Forecasting and Costing, a Core Team on ART to Non-citizens, and a Treatment Guideline Committee. All have USG agencies and PEPFAR Implementing Partners representation.

During the Washington meeting in April, PEPFAR/B with the MoHW Permanent Secretary decided on a list of 71 sites (based on TX_CURR) aligned to the highest disease burdened areas. While PEPFAR will be working to support MPR adoption with fidelity nationwide, the chosen 71 site list is intended to enable PEPFAR and the GoB to achieve national MPR implementation and to demonstrate that achievement.

In addition to the progress reports, members of the HLF, HLF Technical Team, and the TWGs will conduct periodic field monitoring visits to observe implementation progress firsthand and interact with field staff to collect feedback and other relevant intelligence on the process. These field monitoring visits will target DHMTs to conduct joint stakeholder meetings to promote or assess the implementation of new and

Unclassified

existing policy directives or to facilitate and support planned routine DHMT meetings. In most instances, however, these monitoring visits will targets health facilities to identify best practices (best performing sites) or help trouble-shoot identified challenges and implement lasting corrective measures (least performing sites). The USG will form interagency teams to participate in these monitoring visits. These interagency teams will generate formal monitoring reports highlighting the extent to which the MPRs are routinely integrated collectively and individually at sites, and will engage and support relevant MoHW POCs and DHMT/Site leadership on any corrective measures that might be necessary to deploy to ensure fidelity and scale.

The daily monitoring of program activities, including related data collection and analysis will continue to be managed at the DHMT and site levels with support from PEPFAR implementing partners. The USG will also leverage its routine partner performance monitoring process, which also includes site visits, to monitor and support both the DHMTs and the health facilities they oversee. This channel provides a unique opportunity for granular monitoring and the deployment of tailored technical support to help DHMTs and sites achieve their programmatic targets.

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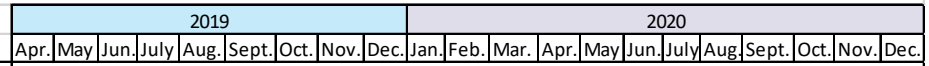
BOTSWANA NATIONAL HIV RESPONSE

Minimum Program Requirements & Milestones



MPR Description	Milestone Description	POC - GoB / USG
Same Day & Fast-Track ARV Initiation	90% of needed ARV NPDs re-deployed in each DHMT	**DPS-HSM**
	Directive issued for ARV @ 24-hour clinics	
	Starter packs & Start/transfer launched	
	Staffing shortages addressed	
	Data collection tools modified	
DSD approaches, including 6M-MMS and 6M-MMD for stable patients, and other strategies to ensure ART coverage and utilization by men and persons 25 or younger	National plan drafted for 3M-MMD & 6M-MMD	**DPS-HSM**
	3M-MMD launched	
	ARV regimen stocks and storage capacity addressed	
	Objective-based framework for DSD developed	
	3 new sites for community ART distribution	
	6M-MMD launched	
TLD Transition Including Transition of NVP	Audit of TLD patients completed	**DPS-HSM**
	Monthly transition progress reports	
	Pending NPV procurements cancelled	
	Excess stocks of Alluvia/NPV donated	
Scale up of Index Testing and Self Testing	HIV-ST launched in 6 districts	**DPS-HSM**
	HIV-ST kits procured for national roll out	
	Active Partner Notification best practice review completed	
	Data collection tools modified	
TB Preventive Therapy	National plan drafted	
	Needed for INH & Pyridoxine assessed	**DPS-HSM**
	DPs funding commitments secured	
	Roll out started (with 2 districts)	

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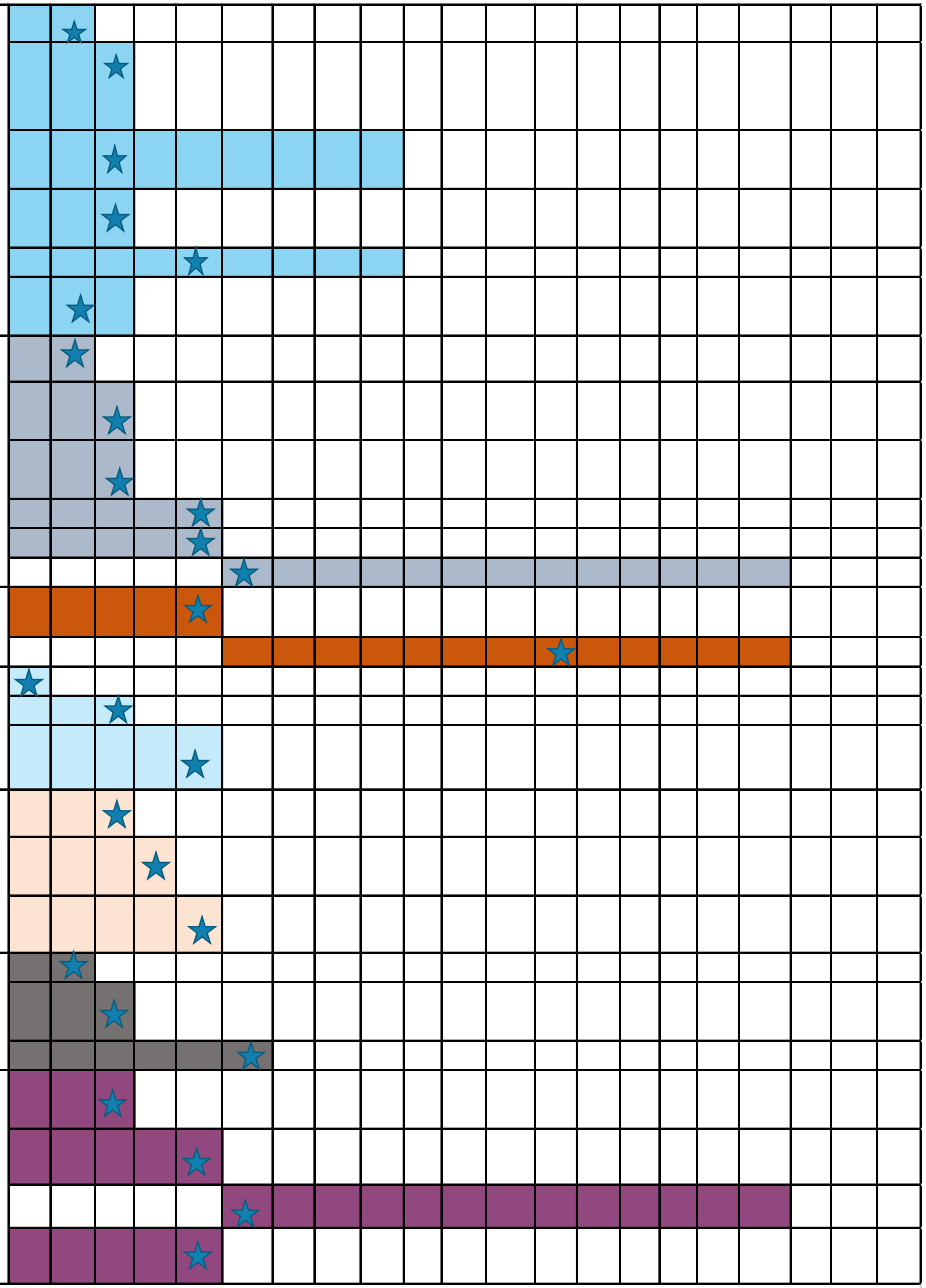
Viral load monitoring for all persons on ART	VL reportable indicators set	**DPS-HSM**	
	Facility VL coverage and suppression baseline and target set		
	IPMS lab nodes installed at facilities on GDN		
	Phlebotomy and data clerks shortage addressed		
	Old equipment replaced		
	Plan for POC Machines in remote facilities developed		
Improve Tracking of Morbidity and Mortality Data	MOHW-led M&E Team formed	**DPS-M&E**	
	TX_ML variables integrated to existing indicators		
	Manual/electronic registers updated		
	TX_ML related SOPs developed		
	Clinicians/data clerks trained		
	First indicator report		
Update data systems to track the layering of DREAMS services	SOUR for data platform completed	**MOHW & NAHPA teams**	
	Data platform launched		
Extend treatment access to non-citizens, who are estimated to account for 7% of PLHIV in Botswana	Policy brief to MOHW	**PS - MOHW**	
	Cabinet decision		
	DPs funding commitments secured		
Allocate at least 40% of PEPFAR resources to local / indigenous partners by October 2020	MOHW briefing completed	**DPS - Partnerships & NC - NAHPA**	
	Briefing of potential local partners completed		
	MOHW support and contribution defined		
Utilize unique identifier to improve tracking of patients	MOHW M&E Team formed	**DPS-M&E**	
	Health data systems modified to flag Omang errors		
	First report of progress		
Health Sector wide M&E Strategy	MOHW-led data integration Team formed	**DPS-M&E**	
	Directive issued to decentralize M&E strategy to DHMTs		
	Routine DHMT data reviews launched		
	Strategic new partnerships on M&E formed		

★ *Symbolizes achievement of the milestone*

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4.3 Supply Chain

Commodities-related issues that may affect the ability of PEPFAR to support the country's achievement of epidemic control include:

- The national supply chain issues that may negatively impact the last mile distribution of required commodities to the patient include inefficiencies, inadequate procurement staffing capacity at CMS, insufficient forecasting technical expertise that may lead to potential stock-outs, and lack of visibility and data from the facilities to CMS – leading to poor consumption data required for a reliable and effective procurement planning by CMS. PEPFAR continues to support capacity building and system strengthening of CMS, to develop more efficient systems and to realize associated cost savings for HIV drugs and other key commodities.
- Stock-outs of essential commodities are periodically experienced at the national level, and PEPFAR/B will usually assist GoB by doing emergency procurement(s); such as for HIV rapid test kits and condoms.
- As a matter of policy, GoB also does not fund commodities such as lubricants for Key Populations, which negatively impact the efforts toward epidemic control. PEPFAR still procures those commodities.

TLD Transition – The country is in the process of transition from Dolutegravir (DTG) and other regimen to the fixed dose TLD. PEPFAR/B, mainly through the PSM Supply Chain mechanism, continues to work with MoHW/CMS team on implementation of the transition plan. While the plan was to start transitioning in November 2018, a potential stockout of key 1st line regimen (Truvada and Atripla) in August 2018 led to a decision to fast-track the transition to an earlier date. It was in that note that the PEPFAR procured TLD shipment had to be brought into the country in August, rather than the initially planned October requested date. Subsequently, the MoHW issued a Savingram to start the TLD transition on September 1, 2018.

Nonetheless, the transition started much slower than it was anticipated; and to date it is still on the 1st phase (of 4) of transitioning, the 1st phase was planned to take two months and the subsequent phases to each last up to six months each. As a result of the delays in implementing the transition according to plan, the other 3 phases are expected to commence by June 2019 at the latest and go to the end of 2019 – i.e. if all goes according to plan

Unclassified

Initial TLD Transition Plan

Phase	Phase I	Phase II	Phase III	Phase IV
Target Initiation Date	Nov 2018 over 2 months	December 2018, over 6 months	Jan 2019 over 6 months	June 2019 over 6 months
Transition Group	Truvada + DTG patients → TLD	NVP based regimens → TLD or DTG	LPV/r based regimens → TLD or DTG	EFV based regimens → TLD or DTG

(See more on the TLD Transition under Section 4.3.1– Commodities)

CMS & supply chain capacity building: PEPFAR has been supporting strengthening continues to build capacity at the Central Medical Stores (CMS) through the USAID-PSM mechanism, with the following investments listed below starting in COP 17 and through COP18. However, based on the budget cuts in COP19 PEPFAR/B will no longer be able to support CMS and will be closing out this activity in COP19.

- A Track & Trace Manager has been seconded to CMS to oversee the implementation of tracking commodities from CMS all the way to facility level to ensure visibility and reliable data flow on consumption, and to improve procurement/distribution of commodities as well as to help avert potential stock-outs and ensure reliability of the national supply chain and availability of drugs where & when they are required.
- The Track & Trace Manager had been responsible for overseeing a team of up to twenty (20) Site Monitors (currently 17 deployed) to various facilities across the health districts in the country; whose duty was to collect and compile consumption data at facilities for submission to CMS to support the mandate of their manager – as well as to build capacity of the GoB health care workers at the facilities in data collection and management.
- A Logistics Management Unit (LMU) Manager was also seconded to CMS to support the areas of drug quantification/forecasting, and procurement of required stock levels to ensure reliability and integrity of the national health supply chain, as well as capacity building of the LMU staff at CMS. The area of quantification, forecasting and planning is one that CMS is more concerned with, and the secondment of the individual had been of great benefit.
- An IT Technical Advisor had also been seconded to CMS to work with the CMS IT section; as well as with both the Track & Trace and LMU Manager to strengthen and build a robust and reliable IT infrastructure between CMS and facilities across the country, to ensure data integrity throughout the supply chain.

The supply chain implementing partner is managed centrally from headquarters. Notwithstanding that, there is a small team in-country that works closely with the PEPFAR team on all commodities/supply chain related issues. Additionally, there are monthly reports submitted to the USAID Health Office in Botswana,

Unclassified

as well as monthly scheduled tele-conferences with all US and locally based stakeholders to discuss pertinent issues and resolutions if required.

4.4 Commodities

ARVs: The Central Medical Stores (CMS) stock situation report for the end of March 2019 shows the following at central level for 1st & 2nd line ARVs in the country:

Table 4.4.1 ARV supply as of March 2019

First Line ARVs	Months of Stock at CMS	Second Line ARVs	Months of Stock at CMS
TEE	3.6	LPV/r 250mg	13.2
TLD	12.1	LPV/r 125mg	4.8
DTG	2.8	ATV/r 400mg	0.1
Truvada	1.9		
ABC300	.05		

The above table shows that the PEPFAR procured TLD stock levels were even higher than the required maximum levels (6 months). The LPV/r 250mg also had very high stock levels, while all the others (except for TEE) were below the required minimum stock levels of 3 months.

HIV Rapid Test Kits (RTKs): While there are no plans to procure RTKs in COP19; PEPFAR has procured and donated the following in support of the national testing efforts in the last year;

- A total of 502,200 tests of the Determine RTKs
- A total of 17,580 tests of the Unigold RTKs
- 31,200 OraQuick self-test kits that are currently being used for both validation and national rollout of self-testing activities led by MoHW

TLD: The TLD Transition Plan has been completed jointly with MoHW/CMS officials. While the original plan was to transition beginning November 2018, the actual plan was fast-tracked to September 1, 2019 instead to avert a potential crisis after learning that some 1st line ARVs (including Truvada & Atripla) were under threat of stockout at the central level (CMS). As a result, PEPFAR requested PSM to bring in part of the original order of 350,000 units of TLD (with an expected delivery of October 2018) into the country earlier than the original delivery date of October. 109,000 units of TLD were delivered to CMS by the third week of August 2018. As a result of this, GoB issued a Savingram to start TLD transition on September 1st 2018. With the following is the transition plan by cohort/regimen:

Original TLD Transition Plan by cohort/regimen

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- Full transition planned to be completed by Dec 2019 with a phased approach;

  - ✓ **Phase-I**: new adult patients + all 1st line and 2nd line patients already on TDF/FTC+DTG.
  - ✓ **Phase-II:** 1st line patients on AZT/3TC+NVP and TDF/FTC+NVP, and substituting all other NVP with DTG.
  - ✓ **Phase-III**: 2nd line patients on TDF/FTC+LPV/r, and substituting all other LPV/r with DTG.
  - ✓ **Phase-IV**: substituting EFV molecules with DTG with the exception of TEE (for TEE there is a discussion to replace it with TAF-ED)

Current Status of the transition

- Phase-I still in progress.
- Out of 908,342 packs procured by GHSC-PSM, 349,816 packs have been distributed by CMS so far (38.5% of total stocks procured).
- Phases II, III, & IV have not yet started (now rescheduled for June 2019).
- In Phase-I, an estimated 43,658 patients were taking TLD by end of February 2019 out of expected eligible patients of about 84,149 (52% uptake).
- Some existing patients are still taking Truvada + DTG and some facilities are still initiating patients on the same regimen.
- Shifting patients off NVP and LPV/r (Phases-II & III) did not begin as planned earlier. Overstock of Alluvia is one of the reasons for the delay. All other adult regimens not eligible for TLD but containing NVP, LPV/r, and EFV will have these molecules (NVP, LPV/r & EFV) substituted by DTG.

All future TLD procurements will be funded by GoB as the PEPFAR funds for ARVs (DTG/TLD) have been exhausted; with the last TLD shipment delivered to Botswana in mid-February 2019.

Of note is that there is an ongoing discussion at the relevant MoHW TWGs to switch patients who are currently on TEE to TAF-ED, instead of TLD.

Male Condoms & Lubricants: While PEPFAR continues to assist the KP program with the procurement of lubricants; male condoms are procured by GoB. There have been no recent shortages or stockouts of condoms, and in mid-February 2019 CMS reported having an overstock of condoms. For COP19 we are planning to procure 1,395,000 pieces of each male condoms and lubricants for the KP program.

GeneXpert Cartridges: The use of GeneXpert as the initial diagnostic test for all presumptive TB cases (targeting priority population mainly PLHIV) is not optimally implemented. Though there are other gaps to be addressed, the supply of cartridges has been one of the key issues. There has been frequent stock-outs and interruptions in GeneXpert cartridges supply especially following the adoption of GeneXpert as initial diagnostic test for all presumptive TB cases. While PEPFAR has budgeted for the procurement of cartridges for COP18, there is no provision for the same in COP19.

4.5 Collaboration, Integration and Monitoring

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4.5.1 Improving Collaboration and integration Across Priorities and Actors

PEPFAR/B has a well-structured interagency collaboration and coordination that was enhanced at the end of 2017 with the development of an Inter-Agency Guidebook. The Guidebook, which is updated annually and discussed at PEPFAR team retreats, was created to bring a higher level of efficiency, transparency, professionalism, and effectiveness to the work, thus moving closer to a shared vision of achieving an AIDS-free generation in Botswana.

I) USG-GoB

Through the leadership of the PEPFAR Coordination Office (PCO), PEPFAR/B convenes regular meetings to share information, discuss strategies and performance, plan, or make joint decisions. PEPFAR/B's standing meetings include: PEPFAR Country Team (PCT) weekly meetings with all PEPFAR staff across USG agencies; PEPFAR Management Team (PMT) meetings every other week with TWG co-chairs and agency leads; and PEPFAR agency leads meetings on alternating weeks. PCO also works very closely with the front office at the U.S. Embassy in Botswana to ensure senior USG leadership awareness and support for the broader PEPFAR policy decision making through the Mission Integrated Country Strategy- (ICS) and related monthly Health Working Group (HWG) meetings.

With the new Permanent Secretary of Health, PEPFAR/B's engagement with GoB has reached new heights. In addition to PEPFAR leadership participation in the newly created Health Leadership Forum, PEPFAR's TWG co-chairs and technical staff from the agencies work closely with a range of MoHW offices to ensure coordination and alignment of efforts in addressing the challenges facing the full implementation of Treat All, including case detection, linkage to care, ART initiation, retention, viral load coverage and viral load suppression. All USG agencies' technical staff are represented on all MoHW-led national TWGs where granular programmatic and related policy options are discussed and recommended. The current nature and level of USG-GoB engagement will be an asset for the strategic direction for COP19, which is to work with the GoB to ensure implementation of the MPRs with fidelity at all districts/sites.

The PEPFAR/B team routinely coordinates and communicates with the GoB, GFATM, multilateral organizations, the private sector, FBOs, and CSOs. Host government and external partners' engagement remain important interactions to help guide the work of PEPFAR implementing partners in the districts, communities, and health facilities. The collaboration between all the multilateral organizations is intended to enable PEPFAR and GoB to achieve national MPR implementation and quality service delivery with impact and demonstrating that achievement.

The PEPFAR Coordinator sits on the Global Fund Oversight and Executive Committees and one of the Agency Leads serves on the Global Fund Country Coordinating Mechanism (CCM).

II) PEPFAR/B FBO and Communities of Faith Engagement Initiative

This is a direct recognition of the critical role played by FBOs and offers a turnaround strategy for countries to fully engage faith and traditional leadership in reaching epidemic control. The nature and demands of the epidemic has changed over the years, which calls for direct engagement of FBOs to play a critical role

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in reaching different priority populations with prevention, care, and treatment interventions. See Appendix E: Addressing Gaps to Epidemic Control including through Communities of Faith for more information on COP19 efforts to strengthen collaboration with FBOs.

III) Implementing Partners

PEPFAR/B has a framework for implementing partner management for each mechanism, which is revisited annually at the time of work plan approval. USG Agency AOR/COR and activity managers are responsible for designing and carrying out partner management plans to ensure accountability for PEPFAR funds and program performance.

The core elements of effective partner management include:

- Routine performance monitoring through USG/implementing partner review of OU-, SNU-, and site-level program results (including data completeness and quality), with frequency (weekly, monthly, or quarterly) determined by partner performance.
- Routine reboot partner management site monitoring visits, weekly MER review, review monthly site level performance, and verify site level results.
- Aggressive financial monitoring to ensure 1) spending is aligned with technical and geographic priorities as defined in the implementing partner's work plan prior to signing approval vouchers and 2) spending does not exceed approved operational plan budget.
- Immediate remediation planning when partner performance is of concern as identified though reboot routine site visits.
- Any partner with <50% of target at 6 months must have a complete evaluation, remediation, and spend plan consistent with underachievement

As a result of these enhanced partner management processes, PEPFAR/B staff have conducted joint interagency site visits and provided real time feedback to IPs through a partner management tracker. This effort, which will continue in COP19, has resulted in significant improvements in the following areas: individual and collected IP site staffing, targeted IP headquarters' technical assistance on client flow, index testing and linkage to care with ART initiation, increased index testing and detection of men, scaling up of universal TB suspect screening, and universal screening for HIV testing eligibility in hospitals. We have seen improved performance among all IPs across the HIV/AIDS cascade. Implementing partners will have to sustain these improvements and show work plans which addresses all the relevant MPRs as the GoB moves forward with MPR implementation. Beyond individual partner agency specific meetings, PEPFAR/B also coordinates joint interagency partner meetings and reboot site visits to ensure transparency and collaboration among all PEPFAR implementing partners. PEPFAR/B agency and interagency partner performance assessment and management are directly tied to improved testing, linkage, initiation on treatment, and viral load coverage, with the expectation of 100% achievement of COP targets.

PEPFAR/B will strengthen and scale up its reboot process in COP19. IPs are expected to design a specific activities to address barriers in several areas, including:

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- testing hard to reach groups, including older men and women
- same-day initiation of ART
- reaching legacy positives
- ensuring retention
- enhancing the understanding of viral load and encouraging patients to ensure it is done annually

Botswana has long provided viral load monitoring for its citizens. Per Botswana guidelines, viral load is provided three times for those starting treatment, twice annually for stable adult patients, and four times a year for children. Viral load coverage improved from 83% to 96% since reboot implementation. Most of the patients who were said not to have a current viral load results were found to actually have valid results in the IPMS. This is due to the fact that all viral load laboratories are connected to IPMS, however, most district hospitals and clinics are not connected to IPMS and are instead either connected to PIMS or are paper based. Going forward PEPFAR/B will support GoB to improve viral load coverage and suppression through:

Lab:

- Refresher trainings on lab commodity management
- Enhanced CQI including personnel and equipment certification, proficiency testing, and site audits
- Additional lab staff training on VL specimen management and continued roll out of the integrated specimen management register
- Collaborate with GoB on referral network review
- Continue to work on the roll out of IPMS Laboratory Specimen module to allow sites to document and track results, and improve turnaround times of results
- Scale up critical reporting by labs for positive EID and non suppresed viral load
- Provide HCAs for data entry and phlebotomy at selected sites

Clinicians:

- Refresher trainings for clinicians on IPMS and results documentation to address the missing results

Clients:

- Development and use of viral load literacy materials
- SMS reminders for clients and triggers at pharmacies to alert clients on viral load testing

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Cross-Cutting:

- Utilize VL champions to follow-up on both viral load and EID results (GoB has started taking this on at site level)
- Continuous use of SIMS dashboards and performance data for remediation of service delivery and quality gaps

In response to M&E human resource capacity gaps at MoHW, COP19 funds will continue to support one DHIS officer and three program M&E officers for PMTCT, ART, and HTS (key programs for MoHW/PEPFAR data alignment). PEPFAR HIS support will focus on:

- PIMS roll-out, system maintenance, training/mentoring: Roll-out of an improved PIMS electronic system to all eligible health facilities in the non-PEPFAR supported districts, and train the Health Care Workers to capture HTC, PMTCT and ART data in the system.
- Secure patient level data transfer: Utilize the Government Data Network (GDN) to transfer data back-ups from stand-alone PIMS sites to the data warehouse.
- Data warehouse maintenance: Provide TA to maintain and manage the DW including conducting key analyses to inform 95/95/95 and act as foundation for HIV case surveillance.
- Strengthen HIV case surveillance: Support will be provided to implement a phased rollout of HIV case surveillance system (starting with sustained districts and eventually national rollout).
- TB patient management system: Provide maintenance support to the TB patient management system Open-MRS.
- Use of DHIS for PEPFAR/MoHW data alignment: Provide TA to MoHW to strengthen utilization of DHIS for site monitoring and reporting.
- Modify IPMS and PIMS to align with the 13 PEPFAR minimum requirements.
- Automate and secure the transfer of PIMS backups and XML reports to the data warehouse and the program DHIS2 platform through the use of mobile networks for sites not on the GDN to improve the completeness and consistency of submission of the backups.
- Continue rollout of IPMS lab modules to sites on the GDN to facilitate close access to lab results by facilities without access to the GDN.
- Finalize dashboards for CBS, EID, VL, ART, HTS, and PMTCT to be used for program monitoring.
- Update PIMS and IPMS database records in high volume facilities to ensure that all patient records are in the EMR's and are ultimately transmitted to the data warehouse.

IV) Peace Corps Volunteers are placed strategically with local implementing partners - NGOs, health facilities, and local government offices – to provide long term support and capacity building in making desired changes for improved linkage and initiation/adherence with particular attention to:

- Programs addressing in school and out of school youth and their supporting environments, and
- Sustainability of systems strengthening activities – such as M&E and IT. For example, the Supply Chain Management program brings Volunteers and their colleagues from a variety of facilities to be certified in the Logistics Management of Health Commodities.

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Together they plan for implementation of change and are collaboratively responsible for ensuring that the change is institutionalized, partner performance and capacity is enhanced and access to commodities is optimized over time. VAST grants are small grants which provide an opportunity for partners of Volunteers to practice the skills learned in capacity building activities. Peace Corps Volunteers submit reports to Peace Corps on a quarterly basis, and Program Managers visit Volunteers and counterparts annually to discuss progress on work plans and offer technical support. Peace Corps also conducts quarterly calls to Volunteers and counterparts/supervisors and holds regular training with Volunteers and counterparts during which challenges and best practices are shared. The inter-agency team also benefits from the insights of 3rd Year Volunteers, who have been selected to work for a year within USG agencies to augment engagement with field-based Volunteers on relevant activities.

V) Other Development Actors: During the COP19 process, PEPFAR/B has made external partners engagement one of its highest priorities with the Global Fund, UNAIDS, and the WHO actively participating in planning meetings. UNAIDS, WHO, and PEPFAR/B have extensively coordinated engagements with GoB, collectively advocating for a solution to the issue of access to free ART for non-citizens. Similarly, PEPFAR/B and the Global Fund have started to coordinate activities and HIV prevention service packages targeting youth, particularly AGYW in the 10-24 age bracket, under the leadership of MoHW and NAHPA.

4.5.2 Strengthening Monitoring

In COP19, PEPFAR/B will prioritize scaling up effective interventions and introducing innovative and improved service delivery models across facilities and surrounding communities to improve case detection, treatment initiation, retention in care and treatment, and viral load suppression through Reboot process.

I) IP Performance Monitoring

PEPFAR/B's weekly Reboot reporting will feed into the quarterly results reviews, coinciding with results reporting in DATIM and the interagency POART process. This process allows for in-depth analysis of partner performance and pre-POART call engagement with implementing partners. Between weekly and quarterly reviews, program results for priority technical areas are reviewed via informal reporting from the implementing partner to the USG management team. At a minimum, informal results reviews take place monthly. USG management teams increase the frequency to weekly results reviews with remediation actions and utilize frequent benchmarks to monitor progress when partner performance is of concern.

Monitoring Programmatic Implementation (by site)

- Each site will run reports at the end of each day to assess data quality
- Review data weekly to assess performance on key indicators
- Provide feedback to sites on any data quality issues and on any gaps to be addressed
- Report monthly to DHIS2 as per MoHW guidelines

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PEPFAR/B performs regular monitoring joint supportive supervisory site visits to allow immediate course correction for poor program or financial performance. When an issue is identified, the USG management team, together with implementing partners concerned, determine an appropriate remediation strategy, track the date of implementation, and get prepared to shift the allocation of targets and resources among partners if performance does not improve quarter over quarter. As a part of this planning, lessons learned from other successful partners as well a technical shifts (global or PEPFAR guidance, policy shifts in country, etc.) should be embedded in any remediation strategy.

II) **Monitoring Policy Implementation**

PEPFAR/B will further strengthen its robust communication strategy to ensure continued implementation of the MPR in COP19. Collaborative sites visits will be conducted to monitor implementation around the country, including:

- Joint Implementation Teams (PEPFAR and MoHW) to monitor and evaluate all HIV sites around the country
- Site dashboards on performance of the MPRs
- Bi-weekly meetings to discuss progress on each of the MPRs based on site visit reports and site level dashboards
- Formal Improvement Plans to address prolonged lack of progress on MPR implementation at site

III) Quality Management and Integrated Analysis

Quality management and integrated data analysis is key in identifying facility and community sites that are under-performing and need to improve implementation. Quality management and integrated analysis will help to determine:

a. What factors and/or barriers contribute to under-performance at sites?
b. What remediation and quality management strategy will improve implementation fidelity, mitigate challenges, sustain quality successes, and achieve outcomes that advance epidemic control?

All PEPFAR/B implementing partners report weekly in reboot meetings, these reports feed into the implementing agencies reporting out via POART on a quarterly basis. PEPFAR/B will show evidence of using quarterly site performance data, especially for outcomes such as fast track ART initiations, linkage to treatment, retention, and viral load suppression and coverage, to prioritize community and facility sites for improvement. Overall, this effort will demonstrate performance improvements from quarter to quarter and indicate the OU's effectiveness in supporting the GoB and ensuring the implementation of both the MPRs and quality HIV services in COP19.

IV) Routine Use of Site Improvement through Monitoring System V4.0 (SIMS)

PEPFAR/B uses PEPFAR's standards-based quality assurance Site Improvement through Monitoring System (SIMS) tool and aims to:

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- Facilitate improvement in the quality of PEPFAR-supported services and technical assistance,
- Ensure accountability of U.S. government investments
- Maximize impact on the HIV epidemic.

With these core principles in mind, a SIMS Site Prioritization List has been developed and will be updated continuously (if needed) on a quarterly basis. This flexibility is to facilitate timely response to emerging bottlenecks and performance challenges. The SIMS Site list, including a clear and detailed justification, was submitted to S/GAC at the end of Q1 this fiscal year (FY19).

4.6 Targets

Table 4.6.1 Entry Streams for Adults and Pediatrics Newly Initiating ART Patients

Entry Streams for Adults and Pediatrics Newly Initiating ART Patients in Scale-up Districts			
Entry Streams for ART Enrollment	**Tested for HIV (APR FY20) *HTS_TST***	**Newly Identified Positive (APR FY20) *HTS_TST_POS***	**Newly Initiated on ART (APR FY 20) *TX_NEW***
Total Men	**89,575**	**8,861**	**9,907**
Total Women	**79,016**	**8,223**	**9,202**
Total Children (<15)	**3,542**	**171**	**195**
Total from Index Testing	**26,563**	**6,500**	**6,175**
Adults			
TB Patients	***1,643***	**119**	**119**
Pregnant Women	***25,451***	**1,102**	**1,056**
VMMC clients	***12,903***	**41**	**41**
Key populations	***5,043***	**759**	**333**
Priority Populations (AGYW)	***17,151***	**1,426**	**1,426**
Other Testing	***142,028***	***10,584***	***12,934***
Previously diagnosed and/or in care		**2,994**	**2,844**
Pediatrics (<15)			
HIV Exposed Infants	***5,810***	**15**	**15**
Other pediatric testing	**3,542**	**171**	**195**
Previously diagnosed and/or in care		**15**	**14**

Table 4.6.2 Expected Beneficiary Volume Receiving Minimum Package of Services

Expected Beneficiary Volume Receiving Minimum Package of Services in Attained Support Districts*			
Attained Support Volume by Group		**Expected result APR 19**	**Expected result APR 20**
HIV testing (all populations)	HTS_TST	**277700**	**120921**
HIV positives (all populations)	HTS_TST_POS	**13885**	**13366**
Treatment new	TX_NEW	**13345**	**13391**

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Current on ART	TX_CURR	**154138**	**166776**
OVC	OVC_SERV	**18254**	**14877**
Key populations	KP_PREV	**1390**	**0**

Table 4.6.3 Expected Beneficiary Volume Receiving Minimum Package of Services

Expected Beneficiary Volume Receiving Minimum Package of Services in Sustained Support Districts			
Sustained Support Volume by Group		**Expected result APR 19**	**Expected result APR 20**
HIV testing in PMTCT sites	*PMTCT_STAT*	**19488**	**15823**
HTS (only sustained ART sites in FY18)	*HTS_TST/HTS_TST_POS*	**277700/ 13885**	**120921/ 13366**
Current on ART	*TX_CURR*	**154138**	**166776**
OVC	*OVC_SERV*	**18254**	**14877**

4.7 Viral Load and Early Infant Diagnosis Optimization

Botswana has 24 viral load laboratories spread throughout the 27 health districts, with 17 in PEPFAR districts. Six of these are also EID laboratories. All these laboratories have a laboratory information system (LIS), Integrated Patient Management System (IPMS). In APR 18 viral load coverage was at 76% while EID coverage was at 62% by 2 months and 81% by 12 months of age. Viral load coverage has improved slightly to 83% by FYQ1 and increased to 96% during reboot. This was achieved through generating a line list of clients with missing viral loads. These were checked in IPMS and results extracted and filed in patients' charts. Out of 20,960 PLHIV without a current viral load, 69% had results already in IPMS. PEPFAR/B engaged Expert Clients and community health workers to follow up patients with missing viral loads and call those whose results cannot be located in the laboratory systems to come for blood collection. Additional manpower was also provided to the laboratories to assist with blood collection and result management.

In COP19, PEPFAR/B intends to maintain these gains by adopting a VL blood collection appointment system. IPMS and PIMS sites will use an inherent appointment system within the HMS and generate list for bleeding point. For manual sites, a manual booking system is to be deployed. 1) As the Encounter register is being updated, the blood collection appointment date will be noted together with the contact details to be followed up proactively to remind them of upcoming appointment (a week before) and when they miss their appointment. Checkpoint for clients to see if they honoured blood collection appointment: Pharmaceutical officer to check from latest encounter if VL is valid and if client honoured blood collection appointment before refill. Reorienting role of FCTO to focus on VL continuum: 1) Review files of clients coming for clinic next day, 2) Check for lab results and if not available on file, check in clinic files/folders and either update PIMS or client file, or check in IPMS, print and file in client records. 3) For those without lab results call and ask them to come in early if blood collection will be done on same day as review or appoint for earliest blood collection date (synchronize with next pharmacy refill date if practical to reduce client multiple visits to facility).

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For EID all the missing results were available in the IPMS. PEPFAR will continue to support data entry clerks at high volume sites for improved patient care at national level to improve analysis and reporting and troubleshooting of PMTCT data that EID. Data Clerks deployed at 6 laboratories that perform EID will continue to support at the laboratory-clinic interface to track and provide follow-up for HIV services provided to HIV-exposed infants. The same initiative of using FCTOs will be engaged to ensure that all EID results are filed before clients come for their review. Additionally PEPFAR/B will ensure that there is coordination between the child welfare clinic, post-natal clinic and ante-natal clinic so that all exposed children are tested on time.

Botswana will ensure viral load and EID coverage of PLHIV and HIV exposed children in far to reach areas and where there is need by considering adopting POC systems. Currently, the country has more than 30 GeneXpert machines which are stationed in the laboratories but not at POC sites. All the viral load and EID laboratories will be monitored for continuous quality control compliance through the use of the viral load/EID score card checklist and the other external assessment. Additionally, PEPFAR/B will ensure quality of testing for both viral load and EID testing by supporting equipment calibration and external quality control monitoring at sites level. Additional support will be provided to ensure quality of TB diagnosis and Cryptococcus antigen diagnosis amongst PLHIV.

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5.0 Prevention Support Necessary to Achieve Sustained Epidemic Control, including PMTCT, OVC, DREAMS, KP, VMMC, and Cervical Cancer

Prevention, specifically detailing programs for priority programming:

PEPFAR/B is implementing several interventions addressing prevention for priority populations. These interventions are delivered through PMTCT, OVC, DREAMS, KP and VMMC platforms. In COP19, PEPFAR/B will receive additional resources through the faith based organizations (FBO) initiative. These resources will be utilized to augment current initiatives and will include previously unreached populations such as those within the FBO community. This section lays out how PEPFAR/B will implement these interventions in FY20.

5.1 PMTCT

PEPFAR/B will continue to support the most effective PMTCT program possible by ensuring that women and their children have access to care and treatment in order to prevent HIV. These services include antenatal services and HIV testing during/post pregnancy; use of ART by pregnant women living with HIV; and infant HIV testing and other post-natal healthcare services.

HIV testing and ART rates are relatively high, while EID requires significant strengthening. Thus, PEPFAR/B will provide support for EID and viral load optimization. The PEPFAR IP will continue to work with Facility Based Linkage officers (FBLO) who function as VL/EID 'champions' to strengthen post-analytic EID and VL results return and turn-around-time in the districts. The VL/EID Champions are qualified PMTCT lay counsellors/HCA who will be deployed at facility level in all districts to help track viral load and EID results between the facilities and HIV laboratories. These Champions will link with “child welfare clinics” within the facility level to identify the missing children and collaborate with community workers to trace missing children. They will provide support at the laboratory-clinic interface to track and provide follow-up for HIV services provided to HIV-exposed infants.

In addition, the role of VL/EID champions is to 1) ensure VL test results are returned in a timely manner from labs to clinics, with priority given to ‘high’ VL results (because they require a clinical intervention) and with priority given to pregnant and breastfeeding women (because of the short window of time to make an intervention that is effective), 2) that clinicians act on the results by making a clinical intervention (such as altering drug regimen) with patients if VL is high.

In terms of CHW’s, their role includes 1) generating lists of women needed to return to the health facility for testing of their babies at 6 and 18 months from PMTCT focal persons, 2) tracking and tracing these women in the community and supporting them to return to the health facility, 3) providing education and counseling to the women on the need to continue accessing services and 4) providing support for adherence.

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Birth cohort registers for HIV Exposed Infants (HEIs) were developed in COP18 and is being rolled out in a phased approach manner to ensure appropriate linkage to testing, care and treatment. The roll out will be finalized in COP19. In support of the PMTCT program, CHWs will continue tracking mother-baby pairs to ensure that infants in the PMTCT program are linked back to the health facilities for early infant diagnosis.

Training and mentoring of health care workers caring for infants and children with HIV exposure or infection will continue in FY20 to ensure that the children of PLHIV in care and newly diagnosed including siblings of these patients have also been evaluated for HIV infection. For instance, when managing an HEI, the health care worker should recommend to the mother that she have her other children tested for HIV infection, even if they appear healthy, unless there is documentation that she did not have HIV infection at the time she was pregnant with or breastfeeding those older children.

5.2 OVC

The availability of both the PMTCT and ARV programs have drastically reduced the number of children born HIV positive and those who are orphaned due to HIV and AIDS. This has changed the OVC landscape, bringing the need for these programs to evolve, adapt, and respond to the changing needs of OVC. PEFPAR/B supported the GoB to implement a national situation analysis on OVC. Currently the GoB is working to finalize the report with plans to disseminate findings before the end of 2019. The findings from this analysis will be used to further inform OVC programs. PEPFAR/B implementation of the OVC program is mainly through two agencies: Peace Corps and USAID. USAID's program is implemented by an IP, PCI while Peace Corps implementation is done by Peace Corps Volunteers (PCV).

In COP19, the OVC program will focus on these priority populations:

- Adolescent boys and girls aged 9-14 year old through school based programs focusing on primary prevention of sexual violence and HIV. Parenting programs will also be in place to reach parents of these adolescents.
- HIV positive OVC aged 0-17 years will be reached using the case management approach and teen clubs for treatment adherence.
- Highly vulnerable 15-17 years that are GBV survivors, young mothers, abusing substances or having psychological or social issues in the home etc. will be reached with specific/targeted interventions to address their specific vulnerabilities.

In the past 2 years, the biggest adaptation for the PEPFAR/B OVC program was the shift to focus largely on the 9-14 year old group for both boys and girls, targeting them with primary prevention of sexual violence and HIV. The focus started during COP17 implementation in the two DREAMS SNUs where PEPFAR/B is implementing both DREAMS and OVC via one implementing partner, PCI. The program has since been extended to non-DREAMS SNUs during COP18 implementation and this will continue in COP19. These services specifically target adolescents who are deemed to have not started engaging in risky behavior and the program equips them with the necessary skills to prevent sexual violence (either as perpetrators or victims), prevention acquisition of HIV for those that are HIV negative and prevent spreading of HIV for those already infected. Implementation is done through schools as the majority of

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the 9-14 year olds are in school. This therefore requires close coordination and collaboration with the relevant GoB ministry, in this case, Ministry of Basic Education (MOBE).

Implementing partners work in partnership with the guidance and counseling teachers to deliver the lessons or modules in the agreed upon curriculum following an agreed upon schedule with some lessons/modules delivered by the IPs while others are delivered by the teachers. The schedule is heavily dependent on the school calendar, as a result there are times when the IPs may go for extended periods without delivering any lessons if for example schools are closed or learners are taking examinations. The curriculum that the IP is using to deliver on primary prevention of sexual violence and HIV is called *Life Skills+*. This curriculum is used in both the DREAMS and non-DREAMS SNUs to ensure uniformity of services offered across SNUs. The curriculum was approved by the S/GAC DREAMS ISMEs before COP17 DREAMS implementation started. It was also recently reviewed (April 2019) and got re-approved with a few recommendations for improvement from the ISMEs. The IPs is working on incorporating the recommendations.

Through OVC and DREAMS platforms, parents of 9-14 year olds are also being reached through parenting programs in order to help parents develop the necessary skills to engage in healthy relationships that promote honest and open conversations. In COP19, the OVC platform will be leveraged to reach FBO leaders and their followers on work with the 9-14 year olds. The work will involve expanding evidence based primary prevention of sexual violence and HIV targeting faith and traditional leaders with *SASA!* faith, *Coaching Boys into Men*, *Faith Matter* (from *Families Matters* Program) in all the SNUs where OVC and DREAMS programs are implemented. The work with FBOs will also include providing FBOs with technical assistance to develop and implement child safe-guarding policies for their own organizations. This work will build on the experience that the current OVC IPs have in this area, having been trained by a USAID centrally funded program in 2017 to design child safe guarding policies for organizations working with children. Additionally, through the FBO funds, a full length documentary will be produced to be used to raise awareness for faith and traditional leaders about primary prevention of sexual violence and HIV faced by 9-14 year olds. This documentary will be disseminated through a national screening tour and roadshow in churches and inter-faith communities to promote prevention and response to sexual violence against children.

To ensure 9-14 year olds that need services beyond those offered in the classroom on primary prevention of sexual violence and HIV, the IP administers a screening tool to the whole class before the primary prevention lessons are offered. Based on the results of the screening, 9-14 year olds who may need additional services are identified and enrolled in the OVC program with consent from their parents or care-givers. PEPFAR/B has a full package of services for 9-14 that goes beyond the primary prevention of sexual violence and HIV piece. This package of services is developed around the four domains of OVC programming which include being healthy, safe, stable and schooled. In addition to providing programs that aim to keep 9-14 years olds healthy, safe and free from violence and HIV infection, OVC programs are also heavily involved in caring for HIV infected OVC as already explained in the section of the SDS that speaks to HIV cascade.

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The program ensures that the HIV status of all OVC being served is captured. The OVC platform works with parents/care-givers to 1) establish HIV status of all OVC, 2) provide HIV risk assessment for all OVC reported as HIV status unknown to ensure they identify OVC most at risk of HIV acquisition and link them immediately to HTS, 3) provide ongoing education and support to parents/care-givers on the need to know their children's HIV status so that parents can provide consent for their children to access HTS, 4) support parents/care-givers to access HTS as needed, 5) support parents in caring for their HIV infected children,6) work with infected adolescents in teen clubs to ensure adherence to medication and 7) work with clinical providers and families to ensure HIV positive children in the OVC program are getting their viral loads and that they are virally suppressed. With COP18, OVC partners have increased their focus in monitoring viral loads of their clients; ensuring that none of their clients have missed appointments and that those who are not virally suppressed receive the support they need to get to viral suppression.

PCVs placed in OVC centers are uniquely placed to directly work with OVC, offering services that cut across from prevention to care and support. These volunteers and their counterparts use age-appropriate interventions aimed at educating OVC about HIV prevention and risk avoidance. The most common interventions include *Grassroots Soccer, PACT* clubs, ASRH camps, and screening and facilitated discussions using *STEPS* and *Shuga* films. Volunteers and their counterparts also incorporate gender norms and gender-based violence awareness into the above activities, as well as substance abuse education, as these are key drivers of transmission.

COP19 will also bring transition of OVC serving organizations. With increased focus on transitioning services to local partners, USAID plans to transition 2 local organizations that are currently sub-partners under PCI to receive direct awards. These local organizations will implement both OVC and DREAMS interventions.

Table 5.2.1 Targets for OVC and Linkages to HIV Services

Targets for OVC and Linkages to HIV Services			
SNU	**Estimated # of Orphans and Vulnerable Children**	**Target # of active OVC (FY20Target) OVC_SERV**	**Target # of active beneficiaries receiving support from PEPFAR OVC programs whose HIV status is known in program files (FY20 Target) OVC***
Bobirwa District		53	56
Boteti District		69	69
Charleshill District		-	0
Chobe District		68	68
Francistown District		45	48

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Gaborone District		1,906	1997
Gantsi District		48	51
Goodhope District		179	203
Jwaneng District		63	59
Kgalagadi North District		28	31
Kgalagadi South District		15	16
Kgatleng District		2,469	2574
Kweneng East District		4,418	4636
Kweneng West District		23	21
Lobatse District		22	22
Mabutsane District		20	20
Mahalapye District		1,997	2064
Moshupa		-	0
Ngamiland District		44	48
North East District		30	31
Okavango District		24	24
Palapye District		26	27
Selibe Phikwe District		13	11
Serowe District		32	31
South East District		605	615
Southern District		898	933
Tutume District		35	31
		13,130	**13,686**

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5.3 DREAMS

PEPFAR/B has been implementing the DREAMS program for close to a year. The program continues to evolve and adapt based on lessons learned and new guidance and direction including having to prepare for reporting on the new indicator AGYW_PREV. The GoB through the National AIDS and Health Promotion Agency (NAHPA) is currently finalizing the National Standard Package of HIV prevention, treatment, care and support for adolescents and young people (AYP) ages 10-24. The PEPFAR DREAMS package of interventions is closely aligned with the package currently being finalized by the GoB. The packages are underpinned not only by the National Programming Framework for Adolescents and Young People, but also the National Strategic Framework (NSF III) which aims to unpack questions such as:

- Who are the AYP at greatest risk of HIV infection?
- Where are they?
- Why are they at risk?
- What needs to be done to address the needs of AYP?

The GoB leads DREAMS, overseeing the implementation of the DREAMS program through the National DREAMS Coordination Unit at NAHPA. This is a unit of three people: DREAMS Coordinator and two DREAMS M&E Specialists. As one of these M&E Specialist positions is vacant, currently the unit is actively recruiting for the position. The unit provides oversight and coordination for the national DREAMS program with regular district coordination meetings and quarterly national coordination meetings. Additionally, the M&E Specialists engage frequently with the DREAMS implementing partners on data-related matters to ensure timely collection, cleaning and reporting of DREAMS data.

In FY20, PEPFAR/B will continue to implement DREAMS programming in the two SNUs of Kweneng East and Gaborone focusing on interventions that empower AGYW, reduce their risk of violence and HIV infection, mobilize communities for change, strengthen families and reduce risk of AGYW's male partners. There will be increased emphasis in using program data to better understand where the program needs to focus, mainly ensuring that all three age bands (9-14, 15-19, 20-24) are receiving layered services and completing the primary package of core interventions, and that the M&E systems used by DREAMS IPs are able to adequately capture service provision.

During FY19 (COP18) implementation, PEPFAR/B was approved to shift programming to maximize efficiency in implementation. For example, all the clinical DREAMS interventions (e.g., PrEP, post-violence clinical care, and contraceptive method mix) were shifted to one implementing partner (FHI360) and almost all the community-based interventions, except for community mobilization and norms change activities implemented by FHI360 through *SASA!*, were shifted to another implementing partner (PCI). In COP19, to streamline programming even more and increase efficiencies for greater impact, *SASA!* will be shifted from FHI360 to PCI so that PCI will implement all non-clinical, community-based DREAMS interventions, including *SASA! FAITH*, funded with FBO funds, to mobilize faith leaders for violence prevention and norms change.

Examples of other community based interventions implemented by PCI include the primary prevention of sexual violence and HIV for 9-14 years through school based programming, parenting using Families

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Matter Program and social asset building for AGYW including young mothers using safe spaces and mentors. DREAMS clinical services, including contraceptive method mix, post-violence clinical care (including HTS), PrEP (including HTS), and condom promotion and distribution will be provided by FHI360 at the community-level and through four MoHW youth-friendly sites (YFS) with two in Kweneng East and two in Gaborone. The YFS coordinators and nurse prescribers in these YFS's had previously received capacity building on the delivery of DREAMS clinical services through BUMMHI. These YFS's are also well-positioned to avail PrEP to breastfeeding and pregnant DREAMS participants who frequent the facilities for various health services.

In response to COP19 Guidance and technical direction in Botswana's PLL, community testing has ceased and HTS is no longer an entry point for DREAMS. As note, though, HTS will be provided for PrEP and post-violence clinical services. To reflect guidance on the cessation of community testing and of HTS as an entry point for DREAMS, PEPFAR Botswana has modified its layering table to move risk-based HTS to a secondary service and this updated layering table has received approval from S/GAC. The PLL also directed Botswana to focus attention in the two areas of i) ensuring provision of HIV and violence prevention to girls 9-14 and their classmates, parents, communities, and religious leaders and ii) ensuring that all DREAMS participants reach completion and that DREAMS SNUs reach saturation.

PEPFAR/B made impressive progress in reaching 9-14 year olds with HIV and violence prevention through school-based interventions during the first year of implementation. To strengthen the program and increase reach for this age group and the communities around them, PEPFAR/B will employ the following strategies:

- *Integration of the three S/GAC-developed HIV and violence prevention modules into the Life Skills+ curriculum for implementation in classrooms and safe spaces*: PCI, the implementing partner for the Life Skills+ curriculum has received the S/GAC-developed modules and has developed a plan for integrating the modules into the curriculum. PCI is currently working with the Ministry of Basic Education (MOBE) Guidance and Counseling Department to agree on the proposed plan. The GoB engagement step is critical for the success of the program.

- *Training all mentors and facilitators in safe spaces on how to respond when someone discloses fear or experience of violence and how to provide first-line support*: First-line support is about the immediate care given to a GBV survivor upon first contact with a relevant service provider. Safe spaces give AGYW an opportunity to develop a trusting relationship with their mentors and facilitators. As a result, the AGYW may choose to go to these providers to share their experiences of GBV, making it important to equip mentors and facilitators with the knowledge and skills needed to respond immediately to survivors, ensuring they can listen with empathy, assess and respond to the survivor's needs and concerns, discuss how to protect the survivor from further harm and help the survivor to connect to available GBV response services and social support. FHI360 will work very closely with PCI to ensure the PCI mentors are trained and provided continuing assistance to be able to respond appropriately when cases of GBV arise.

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- *Shift the implementation of SASA! focusing on community gatekeepers, and use FBO funds to implement SASA! Faith focusing on religious leaders and faith communities*: As already stated above, PEPFAR/B will make some adjustment to implementation of *SASA!* In addition to shifting IPs who will implement *SASA!* in COP19, we will strengthen our efforts to reach community gatekeepers, specifically targeting community leaders and change agents, to more effectively change harmful community norms that perpetuate GBV. Additionally as part of the FBO funds, PEPFAR/B will implement *SASA! Faith* to reach religious leaders and faith communities with violence prevention messaging.

- *Train and provide TA to the police, educators, and social workers on GBV response case management*: In COP18, PCI was funded to work with police, educators and social workers to finalize the development of standard operating procedures (SOPs) on GBV response case management. The initial development of these SOPs was spearheaded by MEASURE Evaluation, unfortunately came to an end before they were finalized. This work is progressing very well with PCI having held several meetings with these service providers to develop these SOPs. In COP19, focus will be on rolling out the SOPs via training and providing technical support to ensure implementation of the protocols. As PCI is also receiving FBO funds in COP19, PCI will extend their focus to working with faith leaders on GBV response and case management. This work will include adapting some of these SOPs to make them specific to faith leaders to ensure the content is relevant to the recipients of the information.

Completion of the DREAMS primary interventions and secondary interventions as needed is critical if we are to make an impact in the lives of AGYW. Additionally, we need to reach an increased number of AGYW in COP19 in order to work towards saturation in the DREAMS implementation SNUs. To do this, PEPFAR Botswana will:

- *Strengthen and increase bi-directional referrals between the DREAMS community and clinical partners*: One of the lessons based on program data from this first year of implementation was poor bi-directional referrals between DREAMS community and clinical partners. This is an issue that PEPFAR/B has already begun working with IPs on to ensure that there are clear systems in place to initiate and follow up on referrals between community and clinical partners. The system includes a DREAMS referral system (paper-based) where a client takes the referral form to the next DREAMS service provider. The initiating service provider remains with a copy to enable them to make a follow up to ensure the referral has been completed. Follow ups are made with the partners and places the clients were referred to, as well as following up directly with the client to ensure they received a service. Additionally, to ensure that bi-directional referrals are being made and completed, M&E teams meet bi-weekly to review data including referrals for services and determine corrective actions if necessary.

- *Convene service days whereby clinical services will be brought to safe spaces:* Service days are important in bringing service providers closer to the beneficiaries. Since safe spaces are a place that brings AGYW together, the idea is to have the clinical partner coming to venues where safe

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spaces are held and providing the needed clinical services on-site. This model ensures that beneficiaries are not always moving from one service provider to another, something that can negatively affect retention in the program. PEPFAR/B IPs are planning to start service days in COP18 so that by COP19 they have perfected how to implement this strategy and can be able to reach increased numbers of AGYW. Service days are also a strategy to increase bi-directional referrals between the clinical and community service providers.

- *Identify PrEP champions who will visit safe spaces and speak to AGYW about the benefits of PrEP, what taking PrEP is like, how to access PrEP, etc.*: PrEP is a fairly new intervention in the Botswana HIV prevention landscape. Some AGYW have refused to take the pill after realizing that it is also an anti-retroviral drug demonstrating a lack of understanding of what it is and how it works. Identifying PrEP champions and bringing them to safe spaces to educate and share experiences on the benefits of PrEP will help to increase uptake of and even adherence to PrEP. Safe spaces will also service as a PrEP adherence platform for AGYW, providing group-based support to DREAMS participants on PrEP.

- *Identify AGYW GBV survivors who are willing to share their experiences with DREAMS participants in safe spaces*: The Botswana GBV indicator survey of 2012 showed that over 67% of women in Botswana have experienced some form of gender violence in their lifetime and that nearly 39% of the women reported experiencing intimate partner violence in the past 12 months. In contrast, 1.2% of Batswana women reported cases of GBV to the police, demonstrating a large discrepancy between those who experience violence and those who report to relevant authorities. These figures illustrate the need to educate individuals, families, and communities on GBV, human rights, and GBV response services, as well as use innovative means to identify GBV survivors and assist them in accessing both clinical and non-clinical GBV response services. Finding GBV survivors who are open about their situations and willing to share their experiences in safe spaces is one method of encouraging AGYW to disclose experience and/or fear of violence and seek services. The work that PEPFAR/B is doing in training safe space mentors and facilitators to appropriately respond to disclosure of violence, supporting clinical post-violence care services, and working with the GoB to develop SOPs for GBV case management will help position service providers to respond to GBV cases.

- *Increase reach of out of school AGYW with combination socio-economic approaches*: As we enter our second year of DREAMS implementation, the program is starting to become stable especially in terms of safe spaces becoming established and functional. During this implementation period, PEPFAR/B DREAMS programming will strengthen its programming on providing socio-economic approaches, especially reaching out of school AGYW including young mothers in safe spaces. The community partner PCI has extensive experience in offering youth employment programs which result in youth placed with potential employers. Additionally, the partner will expand the current *WE GROW* methodology to reach more AGYW. *WE GROW* is a loans and savings program that also covers basic business skills to assist beneficiaries to start and improve income generating programs. The *WE GROW* has traditionally targeted parents and care-givers. It can easily be extended to out of school youth. Other efforts would include linking AGYW to existing GoB

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opportunities for young people to start small businesses and offering the AGYW technical assistance to develop business proposals.

- *Intensify DREAMS partner management through bi-weekly DREAMS M&E check-ins*: M&E is a critical piece in DREAMS. In the past several months of DREAMS implementation, PEPFAR/B has learned about the importance of having strong DREAMS M&E system to track completion of primary services, layering, and progress against targets. PEPFAR/B has also learned the need for IPs to regularly come together to review data, identify gaps and work together to develop and implement solutions. This process will continue with coordination from the GoB DREAMS Coordination Unit.

Furthermore, the PLL directed PEPFAR/B through the MPR 10 to "*update data systems to track the layering of DREAMS services*". PEPFAR/B will report on AGYW_PREV during FY19 Q2 reporting. However, due to a lack of a proper system that allows for a systematic merging, analysis and reporting of layering data, the country was only able to produce the report after external analysis of program data by health information system experts from headquarters. In response to this call from OGAC, PEPFAR/B in partnership with the GoB will work on developing a data system that will improve the efficiency of merging, analyzing and reporting DREAMS data and ultimately improve reporting processes and data quality while also allowing for timelier monitoring of program and partner performance. In addition to the GoB, PEPFAR/B will work closely with M&E systems experts from PEPFAR implementing agencies to provide technical assistance in the design and development of the system. It is expected that the system will be up and running in time for FY20 Q2 reporting (April 2020).

Table 5.3.1 Target Populations for Prevention Interventions to Facilitate Epidemic Control

Target Populations for Prevention Interventions to Facilitate Epidemic Control			
Target Populations	Population Size Estimate (scale-up SNUs)	Coverage Goal (in FY20)	FY20 Target
PP_PREV	15,846	63%	15,000
KP_PREV	7,250	0	0
TOTAL	23,096	43%	15,000

5.4 KEY POPULATIONS

The BBSS II (2017) indicated a 42.8% HIV prevalence among FSW. The highest incidence of new infections was reported among FSWs with highest number of new sexual partners and older age FSWs. The survey also revealed high prevalence of sexual violence leading to forced sex, police confiscation, decline in consistent use of condoms for all partner types (mainly because of "being paid more for not to use condoms", lower number of children of FSW being tested and overall low knowledge of PrEP (6.6%) and majority (84.5%) of FSW willing to take daily PrEP and remain negative.

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Overall HIV prevalence among MSM was found to be 14.8% showing significant increase from the 13.1% in 2012. Only 13% of MSM knew about PrEP and majority (65%) were willing to take PrEP daily to remain negative. 44% of MSM overall report that they had unprotected sex in the past month because they didn't have condoms. 60.5% of MSM reported consistent condom use (a 5% decline from 2012) figures, and 59.7% of MSM engaged in sex work were not using condoms consistently with their clients.

The BBSS II (2017) reported that about 40% of MSM have had female partners in the six months prior to the survey with Maun and Chobe MSM recording the highest percentage. This district variation is in line with the reported sexual identity where most MSM in Maun reported being bi-sexual. There is a slight increase in female partners since 2012 in all districts except Chobe. Most of the female partners MSM had were casual females. Circumcision may be an intervention that could benefit their female partners.

The 2016 Botswana Modes of Transmission Study estimated that HIV incidence rate by exposure category per 100,000 was highest amongst FSW and their clients, MSM and people who inject drugs. FSWs were found to have a mean incidence of 5.3% compared to single women over the age of 25, who have a mean incidence rate of 0.63%. Similarly, MSM have a mean incidence rate of 1.48% versus single men over the age of 25 who have a mean incidence rate of 0.93%. These estimates are consistent with previous studies, which have also highlighted concerns such as inadequate knowledge of the risk of HIV acquisition through anal sex, relatively low rates of HIV testing in the past 12 months – particularly among FSWs, limited use of lubricants, low ART coverage, and barriers to accessing mainstream services because of fears of stigma and discrimination (NSFIII).

Prevention interventions among key populations will therefore play an important role in stemming new infections among key populations. The use of One-stop-shop (Prevention, networking and safe space, HIV testing, treatment initiation and support for retention at one site) will be continued in COP 19. In addition, due to wide dispersal of hot spots as identified in 2017 size estimation survey, the provision of services through outreach at mobile clinics or drop-in centers will be enhanced. PEPFAR COP19 Guidelines recommends the use of WHO's Consolidated Guidelines on HIV Prevention, Diagnosis, Treatment and Care for Key Populations, 2016.

PEPFAR Botswana will implement a Hybrid Models of service delivery for key populations. This is due to lessons learned in the last five years of key populations programing. Stand-alone model may perpetuate the existing stigma against key populations. In 2017 BBSS indicated that FSW across all districts consistently described facing stigma and verbal abuse when interacting with others in their communities. FSW explained that others considered them to be "bad" and would often call them names. Key population CBOs are the main mobilizers of KPs and have had successful outreach programs. However most of these CSOs have not been certified to provide clinical services. But these same groups may be unable to provide ART or other needed clinical services. These CSOs have track record of doing outreach, education, and condom and lubricant distribution. In the Hybrid models, prevention is done through community groups linked to integrated but KP-friendly treatment programs either operated by Tebelopele clinics as direct service delivery of in selected government health facilities as Technical Assistance (TA).

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The 2012 BBSS had indicated that there is a direct relationship between the duration of sex work and HIV prevalence. HIV prevalence jumps significantly from 37% to 59.2% & 71.1% for those who have been in sex work for 2-3 years & 4+ years respectively. To break this certain infection probability and to achieve epidemic control, the KP program will enhance the PrEP program targeting the FSWs between the ages of 16 to 24 years and MSMs in the same age bracket.

In addition to PrEP, condoms and lubricants distribution, stigma and discrimination training for service provider and violence mitigation training, the program will prioritize high-yielding case finding strategies from the community and the facility. Strategies:

a) Use of high risk screening tools
b) Conduct strategic network mapping to identify untested/unlinked KPs
c) Use incentivized approach for peer outreach workers
d) Use peer navigation and expert clients. Trained peer navigators most of whom are living with HIV, serve as role models and provide guidance in facility navigation as well as linkage to other appropriate services.

PEPFAR/B KP program will use risk network referrals and voluntary partner referrals (VPR). Specifically the program will use Voluntary Partner Referrals based on WHOs' partner notification model to:-

i) Expand use and frequency of Enhanced Peer Outreach Approach (EPOA) that engages individuals at high risk of or living with HIV to recruit members of their social and risk network for HTC. EPOA includes performance-based incentives that provide peers with increasing benefits in return for achieving measurable service benchmarks and coupons to track referrals, testing and linkage to treatment.
ii) Index testing that rides on EPOA. Engagement of KP members that are newly diagnosed with HIV to identify their sexual partners and members of their networks.
iii) Use HIV Self-Testing for KPs and their clients. This will overcome stigma and discrimination and fear of loss of confidentiality.
iv) Introduce test for triage among the KP community using self-test kits. KP Community providers will conduct a single rapid diagnostic test. KPs with a reactive test will be linked immediately to a facility for further HIV testing and treatment. Those with non-reactive results and recommended for enrolment into PrEP and other prevention services.
v) Employ ICT to engage and recruit the online population of KP especially those visiting match-making and dating sites. Online outreach makes the program relevant to young and urban populations.
vi) Link eligible HIV negative FSW in Gaborone and Kweneng East to DREAMS project. The testing under DREAMS will be tracked in a different manner.
vii) Make escorted referral for MSM who choose to be circumcised.

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5.5 Voluntary Medical Male Circumcision (VMMC)

In COP19, PEPFAR/B will continue to support the provision and expansion of Voluntary Medical Male Circumcision (VMMC) services targeting eligible males aged 10 years and above in selected districts. The program aims to circumcise a total of 25,000 males through a DSD approach using only the dorsal slit surgical technique. This technique is preferred and mandated by the strategic policy shift in Botswana to minimize occurrence of adverse events related to forceps guided approach.

PEPFAR/B VMMC program will continue to target both the civilians and the military community with high disease burden and low circumcision rates. Modeling will be used to assist with identifying and targeting these communities. In COP19, PEPFAR/B will allocate more that 70% of the overall target to high burden districts with a significant gap in VMMC. Greater Gaborone and Mahalapye districts will continue to be prioritized. It is anticipated that the PEPFAR/B supported program target will represent more than 50% of the national VMMC target.

For rapid impact, the PEPFAR/B's VMMC program continues to strategically target males aged more than 15 years of age. In COP19, PEPFAR/B's VMMC implementing partners will roll out demand creation and communication strategies that emphasize a human centered design, expand sensitization, and improve the uptake for VMMC services among older men. Subsequently, PEPFAR/B will continue to target males aged 10-14 years through school holidays campaigns, this activity constitutes an opportunity to reach more boys through the platform provided by the strong collaboration between MoHW and Ministry of Basic Education.

To ensure continuous quality of services and strengthen prevention and active management of VMMC related adverse events, the program will strengthen the capacity of the CQI team coordinated by MoHW to support quality activities in the VMMC program across all partners. In the past years Botswana VMMC program has progressively introduced use of VMMC reusable kits. In COP 18, the program was mainly relying on reusable kits with almost 70% of VMMC procedures conducted using reusable kits. In COP 19 the program will continue to strengthen this approach and minimize use of disposable kits. However a small portion of disposable kits will be kept as back up to prevent shortage during time of high demand, power outage or autoclave challenges. To minimize the cost and waste generation associated with VMMC disposable kits, PEPFAR/B has transitioned to universalize the use of reusable kits for VMMC in COP19. There is no plan to procure disposable kits in COP19. Consumables to be used with reusable kits and medium size autoclaves will be procured by partners to support this approach. Existing stock of disposable kits are kept as back up to complement reusable kits during time of high demand.

Table 5.5.1 VMMC Coverage and Targets by Age Bracket in Scale-up Districts

VMMC Coverage and Targets by Age Bracket in Scale-up Districts					
	Target Populations	Population Size Estimate (15-29 males)	Current Coverage	*VMMC_CIRC*	Expected Coverage
SNU		(SNUs)	(date)	(in FY20)	(in FY20)

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Greater Gaborone	15-29 years	133,691	28%	8,575	41%
Mahalapye Districts		21,038	31%	2,287	55%
Serowe		8,185	60%	1,427	78%
	Total/Average	162,914	40%	12,289	58%
* This table is limited to 15-29 years olds. VMMC is also offered to boys aged 10-14 years and males aged >30 years, however the priority age group of focus remains the 15 to 29 which represents 40% of the total target.					

5.6 Cervical Cancer Prevention Program

In COP18, PEPFAR/B worked with the MoHW National Cervical Cancer Prevention Program (NCCPP) to adapt the existing program M&E tools to capture disaggregated data that will be reportable in DATIM and implement the cervical cancer prevention strategic shift. A situational assessment was conducted and all relevant policies and tools are in place to support the implementation of the program in COP 19.

In COP18 PEPFAR/B is implementing a scale up plan to increase screening for cervical cancer among women living with HIV (WLHIV) aged 25-49 years at PEPFAR supported high volume ART sites and ensure access to treatment when appropriate. The total target for cervical cancer screening in COP18 is 25,000 of WLHIV on ART representing 38 % of the total WLHIV aged 25-49 years on ART. The program is implemented in 22 PEPFAR supported facilities of which 2 are referral hospitals, 7 districts hospitals, 3 primary hospitals and 12 clinics. At these facilities, cervical cancer screenings are offered at various service delivery points (i.e. IDCC, ANC, and maternity ward). Visual inspection with acetic acid (VIA) method is used to screen women while treatment options available in Botswana include cryotherapy for small lesions and Loop Electrosurgical Excision Procedures (LEEP) for eligible large lesions. All the 22 sites offer VIA screening and cryotherapy treatment while 15 of the sites provide VIA, cryotherapy, and LEEP services.

In COP19, PEPFAR/B will continue to build on the existing platform and strategies to increase cervical cancer screening among WLHIV aged 25-49 on ART in order to reach the set target of 32,359 WLHIV to be screened by the end of the COP year. This target will represent 47, 5% of the total WLHIV on ART at PEPFAR supported sites in COP 19. To achieve this goal we will continue to work with MoHW and the implementing partner JHPIEGO to strengthen cervical cancer screening services. Utilizing existing linkage officers will help increase awareness and linkage to screening services. In addition, close collaboration with care and treatment implementing partners and the facility ARV staff will ensure appropriate health education services are available and successful and systematic linkage to cervical cancer prevention and treatment services for WLHIV are tracked. Cervical cancer screening campaigns will utilize facility mobile clinics to enhance visibility in all supported districts to complement and increase demand and offer services to those who were not reached during routine clinic days. In addition PEPFAR/B supported cervical cancer program will use existing MoHW health education platforms to continue to increase awareness of the importance every other year cervical cancer screening among WLHIV on ART.

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The Botswana MoHW's cervical cancer program has existing capacity to provide treatment services for women with large lesions and those diagnosed with a clinical suspicion of cancer. All women with clinical suspicion of cancer will be referred to the treatment referral centers for further investigations and treatments, these sites are Nyangabgwe referral hospital for the northern region and Princess Marina Hospital for the Southern region. A couple of private hospitals in the Southern region also provide cancer treatment. The implementing partner will work closely with MoHW staff to ensure transportation of client is available for successful referral and patients hand over. Tracking of patient's referral will be done in collaboration with cancer treatment centers to make sure that the program accounts for all referred clients and establish whether they are receiving the appropriate treatment and care.

Following a successful completion of the HPV DNA testing and self-collection demonstration project, the NCCPP is in the process of rolling out the use of HPV DNA testing as a cervical screening option before the end of FY19. In COP19, PEPFAR/B program will support innovations for screening such as self-collection for HPV DNA testing and will work closely with the laboratory team to ensure timely release and availability of result through use of GeneXpert point of care testing. Innovation for treatment may include the addition of thermocoagulation method as a treatment option. To meet the COP19 target, the program will implement an expansion of sites, adding screening hub and spoke in high volume ART setting.

Challenges faced by the program included frequent transfer of trained providers which disrupt the provision of services in facilities. In COP19, the program will continue to collaborate with the MoHW and DHMTs to encourage retention of trained staff and sustain provision of services. Training of service providers for screening and treatment will continue in COP 19 with the objective to constitute a larger pool of service providers and minimize the impact of transfers and attrition. The program's technical advisors and mentors will continue to provide mentorship to newly trained staff until they have reached full competency and confidence. This will help reduce the rate of unnecessary referrals for large lesions treatment. Five screening hubs will be added to the existing sites and at least ten screening spokes will be added to the screening sites network to increase availability of services and ease access for WLHIV in surrounding areas.

In FY19, procurement delays has been a major challenge that affected performance during the first semester. In COP19, the program will ensure that through the implementing partner, commodities procurement is fast tracked and delivered to allow for timely implementation.

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6.0 Program Support Necessary to Achieve Sustained Epidemic Control

The O/GAC has provided $4.2 M in Acceleration Funds to implement two major activities that are critical for Botswana to reach epidemic control.

6.1 Health Information System Strengthening (Reference Appendix C)

Data management and collection limits the GoB's ability to monitor the response to the HIV epidemic. PEPFAR/B has been working closely with the MoHW Leadership in COP 18 on the data alignment and strengthening site level patient record keeping. In COP19, PEPFAR/B will continue its work with the MoHW to improve the Electronic Medical Record Systems around the country and take proactive steps to integrate the various data systems so that accurate data can be obtained in a timely manner. Critical barriers to be addressed include:

- Insufficient capacity within MoHW to develop and rollout a centralized version of PIMS.
- The stand-alone version of PIMS hinders real time sharing of key patient data across sites and systems.
- Inadequate maintenance support to GDN infrastructure and lack of network connectivity for sites not on the GDN.
- Lack of an interoperability layer to enable core systems to share data between sites and with the national data repository in close to real-time mode.
- Inadequate capacity of the data warehouse (DW) to manage and process huge amounts of transactional data that will be available following PIMS centralization.
- Limited ability of the DW to show dynamic dashboards for key epidemic control indicators.
- Many unused modules in the system making it network-heavy and less useable.

Of the $4.2 million in Acceleration Funds, $2.3 million are resources provided for the data systems strengthening activities to address the challenges listed above, and will go towards:

- Development and rollout of a centralized PIMS II v4 system to over 400 MoHW sites (with technical assistance provided by an IP).
- Optimization of the Government Data Network (GDN) and setup a limited mobile data network for sites not on the GDN.
- Optimize the Integrated Patient Management System (IPMS) for improved efficiency and utilization.
- Establish a middleware solution to make PIMS, IPMS and other key data systems (such as unique identifier (Omang) registry, Cancer registry, TB Open-MRS, Births and deaths registries) interoperable to enable them to share key data such as patient outcomes in close to real time.
- Improve data warehouse capacity to serve as a war room with the appropriate data mining and analytics capabilities (business intelligence tools with dynamic dashboards).
- Technical assistance to review the M&E Framework, develop metadata dictionary for the M&E Framework, rationalize and harmonize data collection and reporting tools, develop and

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disseminate sector reporting protocols/guidelines, strengthen M&E partnership structures at national and district level to foster data dissemination and use.

6.2 Free HIV Treatment for non-citizens

Documented and un-documented non-citizens living in Botswana are still ineligible for publically-funded ARVs, despite the launch of the "Treat All" policy in June 2016, which provides all people living with HIV in Botswana – regardless of their CD4 count – with free lifesaving treatment. The Botswana Combination Prevention Project (BCPP), conducted in 15 rural and peri-urban communities between 2013 and 2016, found that only 27% of non-citizen PLHIVs were receiving treatment vs. 71% of citizen PLHIVs. Furthermore, the study found that while citizens and non-citizens had similar prevalence rates — 20 percent for citizens, 22 percent for non-citizens — non-citizens were much more likely to be unaware of their HIV status; 63% of the non-citizens who were found to be living with HIV were not aware of their status. This disparity undermines the successful implementation of the government of Botswana's "Treat All" strategy.

More recent data from PEPFAR program activities show that in COP17, 13% of HIV positives (2,660 of 19,838) identified at PEPFAR supported sites were non-citizens. In COP18, Q1 results show a continuing trend with the overall proportion of non-citizens among newly diagnosed HIV positives at about 10% (287 of 2,871).

Since August 2018, PEPFAR/B has worked with UNAIDS and other stakeholders to refine a policy brief estimating the size of the non-citizen population and the cost-benefit analysis associated with offering free treatment to those who cannot afford it on their own – an estimated 22,000 PLHIV. The brief concludes that to address the HIV treatment of non-citizens, GoB would need an additional total investment of $18 million for the period 2018 through 2030 —an average of $1.4 million per year. Moreover, by not acting now, the government increases the risk of a) not meeting the "Treat All" goals for epidemic control, b) incurring an additional $116 million expenditure to treat new HIV and TB infections, and c) an additional 23,000 new HIV infections among citizens.

The Minister of Health and Wellness has assured the U.S. Ambassador that his ministry is taking seriously its commitment to implement all MPRs, and he has raised the issue of providing free HIV treatment to non-citizens to Botswana's Parliament. The Office of the Global AIDS Coordinator (S/GAC) has approved conditional catalytic funding of $1.9 million to MoHW to support treatment for non-citizens following Cabinet's approval of the policy change and pledge of future budget support.

The specific outline of a non-citizen PLHIV program will depend on the government's subsequent policy directives and implementation guidelines. Implementation could take the form of either direct service delivery, as currently done for the refugees, or a technical assistance package provided to select MoHW public facilities. Nonetheless, PEPFAR/B support the MoHW and could cover the following package of services on an as needed basis:

- HIV testing that includes EID using DBS technique
- Limited HRH support
- Facilitated linkage to ART Nurse Prescriber

Unclassified

- Counselling and post testing support services
- Clinical consultations including screening for opportunistic infections (OI)
- PMTCT- ARV services
- Lab-baseline, CrAg and VL testing
- ARV drugs and lab supplies
- Referral to other services
- KP friendly ART services
- Support for retention

7.0 Staffing Plan

As part of the COP19 process and with the significant budget reduction, PEPFAR/B examined its interagency staffing footprint and organizational structure. The staffing profile reflects cross-cutting technical support to the priority budget codes. CDC M&O funds and some of its administrative staff included in COP19 funding support the management and associated procurement of the Gaborone West "GWest" facility shared by CDC, USAID, DoD and the PEPFAR/B Coordination Office, which is not located within the US Embassy compound.

Long-Term Vacancies

The USAID Health Office Director position has been vacant since July 2018 when the last Director moved on. The replacement is expected this FY. In addition. USAID currently has three previously approved positions that remain unfilled (1) Prevention Specialist, (2) Clinical Care Specialist and (3) Strategic Information Specialist. These positions are currently under recruitment with support from the USAID Southern Africa Regional Mission, after being put on hold due to funding uncertainties and are expected to be filled before the end of the FY.

CDC Botswana has one long-term vacancy (Associate Director of Science) that was affected by the hiring freeze and the slow classification process in COP18. This position and three others (Laboratory Specialist, Procurement Specialist and Program Management Assistant) will be left vacant due to budget cuts. Should CDC Botswana realize savings, it will prioritize hiring for the Laboratory Specialist given the strong emphasis on laboratory technical expertise needed for viral load coverage and suppression.

New Positions

There are no new positions being proposed in COP19.

Overview of the CODB

The overall Botswana CODB decreased by 22%. The decreases were due to the overall OU cut in funding between COP18 and COP19. Specifically, by agency, CDC's CODB decreased 17% mostly due to the loss of the Associate Director of Programs (ADP) international direct hire position and converting an Associate

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Director of Management and Operations (ADMO) direct hire to LES. CDC is also holding off on hiring 4 vacancies (Lab, ADS, Procurement Agent and Program Management Assistant). The shared maintenance cost fell 5% from $708,164 to $673,653.

USAID's CODB decreased by 31% from COP18 levels. The decreased funding by USAID includes the loss of one expatriate position, Sr. Communications Advisor, which was eliminated due to funding reductions. This will have a dramatic impact on communications efforts for USAID and PEPFAR in COP19. In addition, USAID has, for COP19, reduced its funding to the Regional HIV/AIDS Program (RHAP) from $500,000 in COP18 to less than $50,000 in COP19. This is a token amount as Pretoria understands the nature of the budget cuts to USAID/B and is allowing Botswana to only minimally support RHAP this year. Additionally, as in past COPs, USAID's CODB includes the PEPFAR Coordinator and Deputy Coordinator salary support. Because of this, the USAID staffing footprint appears to be 19, while functionally, just 17 staff will be managing USAID programs in COP 18.

Peace Corps' CODB decreased by 30% to support COP19's reduction. Peace Corps was required to apply COP18 pipeline in the amount of $40,826 and has now exhausted all pipeline.

DoD's CODB decreased 5% to support one LES Program Manager, and the State Department's CODB (PEPFAR Coordination Office) remained constant to retain one LES Communications Advisor and one EFM Policy Specialist.

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APPENDIX A -- Prioritization

Continuous Nature of SNU Prioritization to Reach Epidemic Control

Table A.1 Attained: 90-90-90 (81%) by Each Age and Sex Band to Reach 95-95-95 (90%) Overall

SNU	COP	Prioritization	Results Reported	Attained: 90-90-90 (81%) by Each Age and Sex Band to Reach 95-95-95 (90%) Overall																					
				Treatment Coverage at APR by Age and Sex																					
				<1		1-4		5-9		10-14		15-19		20-24		25-29		30-34		35-39		40-44		45-49		50+	
				M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F
Greater Franciatown Districts	COP 18	Sustained	APR 19	10%	0%	51%	42%	85%	76%	50%	50%	92%	81%	99%	62%	106%	51%	113%	60%	118%	79%	120%	95%	121%	105%	125%	111%
	COP 19	Sustained	APR 20	19%	19%	20%	19%	86%	91%	58%	56%	93%	76%	99%	69%	106%	68%	111%	69%	116%	80%	118%	95%	119%	103%	119%	108%
Greater Gaborone Districts	COP 18	Sustained	APR 19	6%	0%	16%	17%	63%	64%	46%	44%	73%	59%	78%	48%	84%	39%	89%	47%	93%	62%	95%	74%	98%	81%	105%	86%
	COP 19	Sustained	APR 20	15%	15%	12%	11%	67%	67%	44%	44%	77%	62%	81%	54%	86%	47%	90%	53%	93%	65%	95%	77%	93%	83%	93%	87%
Serowe/ Palapye Districts	COP 18	Sustained	APR 19	12%	11%	49%	44%	20%	18%	78%	78%	125%	101%	135%	84%	144%	68%	153%	81%	160%	106%	164%	128%	165%	140%	170%	148%
	COP 19	Sustained	APR 20	35%	33%	28%	29%	114%	114%	76%	75%	115%	93%	124%	93%	133%	100%	141%	93%	148%	98%	151%	118%	152%	129%	152%	136%
Southern/Moshupa Districts	COP 18	Sustained	APR 19	0%	6%	17%	21%	44%	44%	30%	30%	48%	41%	51%	32%	55%	26%	59%	31%	61%	41%	63%	49%	63%	54%	68%	57%
	COP 19	Sustained	APR 20	9%	9%	9%	9%	45%	43%	30%	29%	54%	46%	59%	44%	61%	40%	64%	44%	66%	50%	67%	56%	65%	59%	65%	63%
Goodhope District	COP 18	Sustained	APR 19	0%	0%	26%	16%	63%	64%	47%	46%	75%	63%	80%	52%	86%	42%	91%	49%	95%	64%	98%	77%	98%	85%	98%	90%
	COP 19	Sustained	APR 20	0%	0%	11%	11%	76%	77%	51%	49%	78%	65%	84%	59%	87%	50%	90%	58%	92%	71%	93%	80%	93%	84%	92%	87%
Mahalapye District	COP 18	Sustained	APR 19	18%	0%	15%	26%	69%	70%	47%	47%	75%	61%	80%	50%	86%	40%	91%	49%	96%	63%	98%	76%	98%	84%	98%	89%
	COP 19	Sustained	APR 20	17%	16%	8%	9%	70%	68%	45%	44%	99%	85%	100%	83%	97%	73%	95%	82%	95%	94%	96%	96%	94%	94%	94%	95%

Unclassified

Table A.2 ART Targets by Prioritization for Epidemic Control						
Prioritization Area	**Total PLHIV**	**Expected current on ART (APR FY19)**	**Additional patients required for 80% ART coverage**	**Target current on ART (APR FY20) *TX_CURR***	**Newly initiated (APR FY20) *TX_NEW***	**ART Coverage (APR 20)**
Attained						
Scale-Up Saturation						
Scale-Up Aggressive						
Sustained	**369,707**	**154,175**	**0**	**299,004**	**19,109**	**81%**
Central Support						
Commodities (if not included in previous categories)						
Total	**369,707**	**154,175**	**0**	**299,004**	**19,109**	**81%**

Unclassified

APPENDIX B – Budget Profile and Resource Projections B1. COP 19 Planned Spending

Table B.1.1 COP19 Budget by Subprogram by Interaction

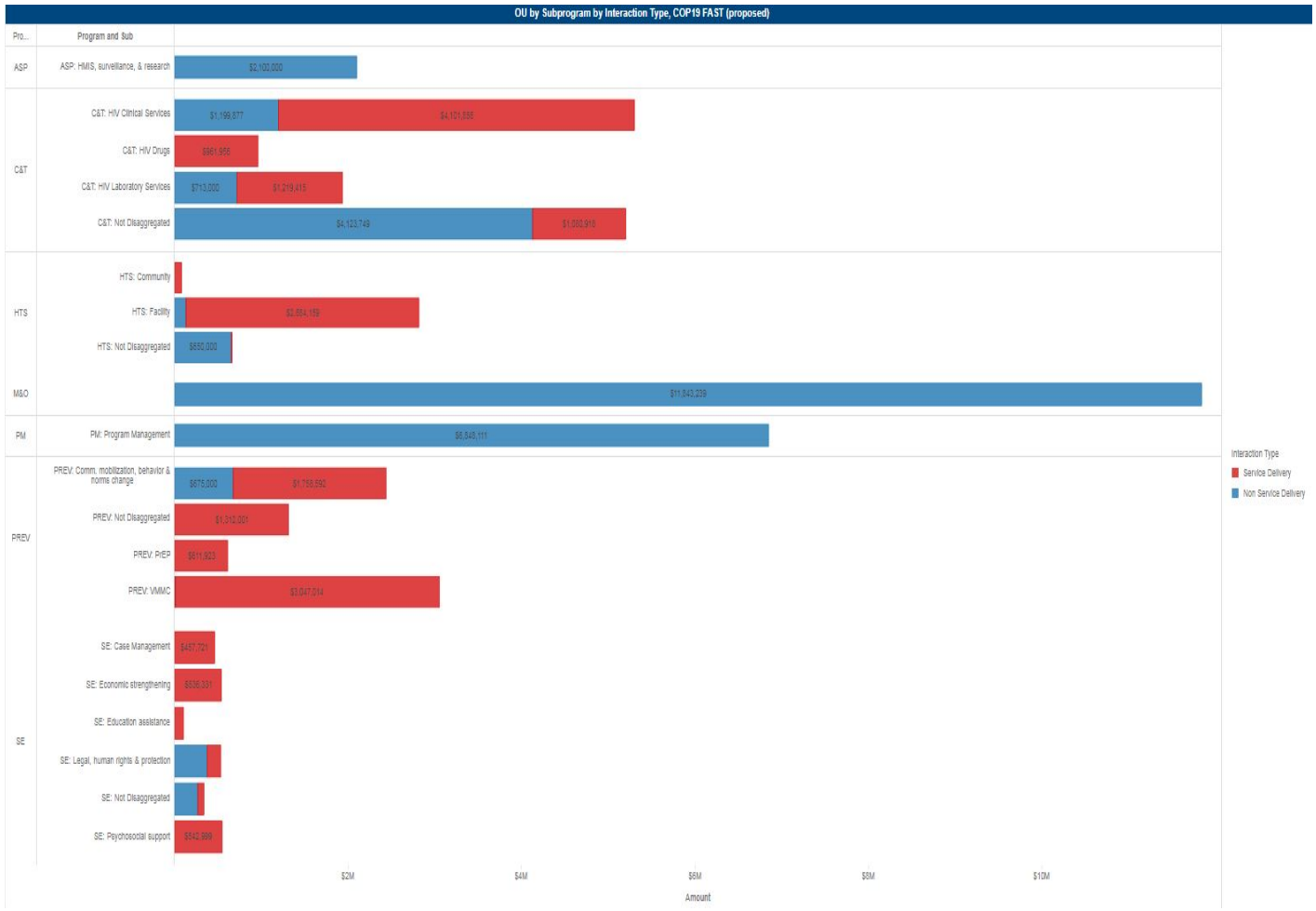

Table B.1.2 Total Funding Levels

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Applied Pipeline	New Funding	Total Spend
$11,784,246	$35,863,384	$47,647,630

Table B.1.3 Resource Allocation by PEPFAR Budget Codes

Initiative Type	Fiscal Year	2020
	Budget Code	Amount
Planning Level	APPLIED PIPELINE	$11,784,246
	CIRC	$1,614,647
	HBHC	$4,996,796
	HKID	$1,559,844
	HLAB	$761,838
	HTXD	$557,731
	HTXS	$9,242,042
	HVAB	$2,454,626
	HVCT	$4,328,231
	HVMS	$4,623,794
	HVOP	$636,095
	HVSI	$2,254,585
	HVTB	$1,256,968
	MTCT	$173,758
	PDCS	$1,204,792
	PDTX	$197,637

Unclassified

Table 6-E (Entry of Above Site Programs Activities)

Funding Agency	PrimePartner	COP19 Program Area	COP19 Beneficiary	Activity Budget	COP19 Activity Category	Key Systems Barrier	Intervention Start	Intervention End	COP19 Benchmark
HHS/CDC	MINISTRY OF FINANCE AND DEVELOPMENT PLANNING	ASP: HMIS, surveillance, & research	Non-Targeted Pop: Not disaggregated	$ 800,000	HMIS systems	Insufficient capacity within MOHW to develop and rollout a centralized version of PIMS.	COP19	COP19	420 420
HHS/CDC	MINISTRY OF FINANCE AND DEVELOPMENT PLANNING	ASP: HMIS, surveillance, & research	Non-Targeted Pop: Not disaggregated	$ 150,000	HMIS systems	Inadequate capacity of the data warehouse (DW) to manage and process huge amounts of transactional data that will be available following PIMS centralization. Limited abaility of the DW to show	COP19	COP21	None 420
HHS/CDC	MINISTRY OF FINANCE AND DEVELOPMENT PLANNING	ASP: HMIS, surveillance, & research	Non-Targeted Pop: Not disaggregated	$ 150,000	HMIS systems	Information systems not being inter-operable; Inadequate maintenance support to GDN infrastructure and lack of network connectivity for sites not on the GDN.	COP19	COP21	420 420
HHS/CDC	MINISTRY OF FINANCE AND DEVELOPMENT PLANNING	ASP: HMIS, surveillance, & research	Non-Targeted Pop: Not disaggregated	$ 250,000	HMIS systems	Inadequate capacity of the data warehouse (DW) to manage and process huge amounts of transactional data that will be available following PIMS centralization. Limited abaility of the DW to show dynamic dasboards for key epidemic control indicators.	COP19	COP21	270,000
HHS/CDC	MINISTRY OF FINANCE AND DEVELOPMENT	ASP: HMIS, surveillance, & research	Non-Targeted Pop: Not disaggregated	$ 150,000	HMIS systems	There are a many unused modules in the IPMS system making it network-heavy and less useable.	COP19	COP19	N/A

APPENDIX D – Minimum Program Requirements

OU	Key Policy advancements including COP19 minimum program requirements (MPRs)	Status of policy change	Milestones
Botswana	Increased engagement and leadership by the Government of Botswana (GoB).	The Permanent Secretary in the Ministry of Health and Wellness (MoHW) has agreed with the importance of adopting, with fidelity and scale, all COP19 policies recommend for Botswana. A high-level "Health Leadership Forum" and multi-stakeholder working groups have been established to ensure process for making policy progress. POCs from the MoHW are being designated for each required policy change. The POC is tasked with setting timelines, tracking and reporting on implementation progress, and convening the right technical organizations for contribution. The USG and other non-GoB partners are fully represented in the process. National objective defined for each minimum requirement. POCs identified at PS and Deputy PS levels from GoB and technical staff from the USG Interagency team.	National and facility level targets are being established across policy priorities. National meeting with all DHMT Leads schedule for 04/15/2019; MPRs main topic of discussion. Milestones, timelines, and POC defined pending PS/Health Forum approval on 04/16/2019.
Botswana	Adoption and implementation of Test and Start and fast track linkage. In February 2019, the GoB issued a "Savingram" circular to all treatment clinics and is conducting site visits to ensure	Ongoing- Reboot began February 2019 Treat All as a policy was adopted in 2016 but has lagged in implementation. Site visits are being used to evaluate and improve linkage data and to adapt data collection to include age, sex, risk groups.	1. Need based re-deployment completed for at least 90% of ARV Nurse prescribers in each DHMT to IDCCs and 24-hour clinics offering HIV services - June 2019 2. Directive implemented for all 24-hour clinics to provide HIV care, including ARV dispensing 24/7 - June 2019

Unclassified

Botswana	uptake of key policies including test and start, linkage, retention, and viral load coverage and suppression.	The best performing sites and best practices are being identified. Cross-site and cross-district learning opportunities will be arranged to improve treatment policy uptake and high quality application. National Objectives: **Fast track**: Increase Fast-Track ART initiation rate to 95% nationwide at all sites by March 2020 **Same Day**: Implement site specific solutions to drastically improve Botswana's Same Day ART initiation rate to at least 50% across sex, age, and risk groups by March 2020	3. Directive implemented for every health facility providing HIV testing to issue Starter Packs and adopt "Start and Transfer" practice - June 2019 4. Needs for additional operating hours assessed and met in localities where there are no 24-hour clinics - July 2019 5. Observed staffing shortages in DHMTs/facilities addressed by hiring or outsourcing to private sector and NGOs - September 2019 6. Existing data collection tools modified to capture fast-track initiation data per site/DHMT disaggregated by age, sex, and risk groups - June 2019
Botswana	Multi month dispensing, multi-month scripting, and other differentiated service delivery approaches adopted.	GoB agreed to move to 3M-MMD in February 2019 and 6M MMS at COP19 meetings in March. Necessary directives are being prepared and disseminated. Site visits and patient surveys are informing the adoption of extended hours and other DSD approaches at high volume sites. National objective: Roll out immediately 3M-MMD across all health districts by September 2019, and identify and implement other relevant DSD to achieve optimal treatment and VL suppression rates in line with Botswana's epidemic control objectives and timeline.	1. Plans for national rollout of 3M-MMD and 6M-MMD drafted – June 2019 2. Roll-out of 3M-MMD started by May 2019 (for TLD stable patients) and 6M-MMD started by January 2020 3. Needs for appropriate ARV regimen stocks and storage capacity addressed - June 2019 4. Objective-based framework developed to guide facilities and districts in the choice and implementation of relevant DSDs – August 2019 5. Three new sites for community ART distribution (3M-MMD) identified and started – September 2019
Botswana	Signed commitment to provide TB preventative treatment (TPT) for all PLHIVs.	Letter signed March 2019	1. Nationwide TPT implémentation plan – May 2019 2. Nationwide needs for additional INH and Pyridoxine assessed – May 2019

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Botswana		Conducting implementation readiness activities in two districts for broader rollout in all PEPFAR districts by October 2019. National objective: Re-initiate TPT for all PLHIV at all ART sites as an integral and routine part of the HIV clinical care package by 31st March 2020.	3. Funding commitments from Development Partners for INH and Pyridoxine procurements secured - June 2019 4. Rollout of TPT plan launched in Kgatleng and South East districts with INH and Pyridoxine – June 2019
Botswana	Index Testing – commitment to explore the transition from passive partner notification to active.	MoHW Permanent Secretary has committed to review issues of client confidentiality and experiences in surrounding countries with an eye for modifying index testing SOPs to enable active index client partner notification. Scoping of legal environment completed and the national HTS TWG has recommended the adoption and implementation of Active Partner Notification. National objective: Scale up Index testing and self-testing modalities nationwide starting in May 2019 and reaching full scale by January 2020 as a means to annually reduce new HIV infections and set Botswana on the path of its 95-95-95 goals.	1. National rollout of self-testing launched, starting in 6 high burden districts for select groups (Men, MSM, FSW, AGYW) – May 2019 2. Needs for additional self-testing kits for national rollout assessed and kits procured – August 2019 3. Review of best practices on Index Testing with fidelity, especially using Active Partner Notification completed – May 2019 4. Directive issued to implement Active Partner Notification for Index Client – May 2019 5. Existing data collection tools modified to capture and report on key indicators – i.e., yield / acceptance / distribution – disaggregated by age, sex, and risk groups – June 2019
Botswana	Self Testing – commitment to rollout HIV-ST nationwide. (combined with Index Testing above)	HIV-ST will be rolled out for select KPs in the 6 high burden districts as planned in COP18. A TWG will develop an implementation plan for nationwide general population use and roll out.	(combined with Index Testing above)
Botswana	TLD transition	MoHW is on track to phase out NPV use and transition to TLD. Commitment to complete TLD transition re-affirmed by the PS at the last Health Forum	1. Audit of remaining patients to complete the TLD transition completed - May 2019 2. Monthly "TLD Transition" progress report issued for each DHMT - May 2019

Unclassified

		National objective:	3. All pending procurements of Alluvia/NPV cancelled – April 2019 4. Excess stocks of Alluvia/NPV donated or discarded – May 2019
Botswana	Treatment of Non-citizens GoB funds the majority proportion of the national HIV response and for the first time in recent years is revisiting their citizens only policy. Non-citizens are estimated to account for 7% of PLHIV in Botswana.	MoHW is currently circulating a Memo for internal clearance; the Memo recommends ART for non-citizens to the Cabinet; MoHW has submitted a letter to PEPFAR/B requesting technical and financial support to GoB over a 3-5 year period for providing ART to non-citizens. This PEPFAR support would ensure a smooth transition to including non-citizens in the existing treatment systems. MoHW memo recommending treatment of non-citizens cleared internally; Policy recommendation introduced to cabinet for approval/adoption on 04/10/2019; decision pending. National objective: Discuss, identify, and implement immediately solutions to provide ART treatment to HIV positive non-citizens at public facilities.	1. Policy brief on "ART to Non-citizens" completed and submitted to MoHW – completed March 2019 2. Cabinet decision on Policy shift issued - April 2019 3. Funding commitments from Development Partners secured - April 2019
Botswana	The MoHW has acknowledged the value and need for quality data, human capacity, and infrastructure to leverage data for decision making and achieve HIV epidemic control. Data, at the national level, in real time, and of high quality, has been identified as the	GoB kicked off a national HIV and TB household survey (BAIS) on April 2. GoB created new M&E Department to help integrate its various data platforms. Working to integrate IPMS, PIMS, CBS, and the data warehouse with the Civil and National Registration System and the Births and Deaths	1. MoHW data integration team established - June 2019 2. Directive issued to define and decentralize M&E strategy to DHMT level - June 2019 3. Refresher training for DHMT leadership on use of M&E data to guide program initiatives - Sept 2019

Unclassified

	major challenge to ensuring a successful implementation of PEPFARs COP19 policy requirements.	Registry in order to automatically validate Omang in real time, verify/retrieve deaths and causes of death, and retrieve new patients, patient encounter events, CD4, VL, morbidities, regimens, etc.	4. Strategic new partnerships on M&E (e.g., BHP, ACHAP, UB, private sector, NGOs) - July 2019
Botswana	Data systems must be updated to collect morbidity and mortality data	GoB has agreed to track TX_ML indicator and train providers to report it consistently. National objective: Review the national data collection systems (both manual registers and electronic medical record management systems) to incorporate the TX_ML variables;	1. Dedicated MoHW/M&E Team formed to oversee implementation across the entire healthcare system (public/private/NGOs) – May 2019 2. A revised Treat All indicator set that includes TX_ML variables - June 2019 3. Updated manual registers and electronic medical record management systems - June 2019 4. SOPs for documenting TX_ML developed -August 2019 5. Trained clinicians/data clerks on SOPs - August 2019 6. First indicator report covering at least 90% all PLHIV on ART
Botswana	Address and resolve policy barriers to achieve viral load monitoring for all persons on ART	National objective: Set up a system to monitor the VL of each person on ART across all ART sites nationwide by October 2019 and require facilities and districts to routinely monitor and report on VL coverage and suppression.	1. Set of VL reportable indicators disaggregated by age, sex, and risk groups developed – May 2019 2. VL coverage and suppression baseline and target set for each health facility – June 2019 3. Progress update on IPMS lab nodes installation in facilities in need – May 2019 4. Needs for additional phlebotomy and data clerks in each VL lab assessed and addressed through hiring or outsourcing required services to private sector – June 2019 5. Progress update on replacement of old and low throughput equipment – June 2019

Unclassified

APPENDIX E – Addressing Gaps to Epidemic Control including through Communities of Faith

Faith Based Organizations (FBO) and Communities of Faith Engagement

SUMMARY:

In COP 19, PEPFAR/B has been selected as one of the countries to receive central support through the FBO and Community Initiative in the amount of $2.45 million, in order to accomplish priority activities, as identified by the FBO TDY visit that took place August 27-31, 2018. Of the total allocated to PEPFAR/B, USAID will receive $1,225,000 and CDC will receive $1,225,000. Out of this total of $2.45 million, PEPFAR/B must program half of it ($1,225,000) towards primary prevention of sexual violence and HIV among 9-14 year old boys and girls and reaching men. In addition to the information on funding from the planning level letter (PLL), Botswana received additional guidance from OGAC, identifying two priority areas to focus on:

1. Preventing sexual violence and HIV risk in 9-14 year old girls and boys
2. Engaging communities of faith to understand the epidemic, raise community awareness, and bring critical prevention and treatment interventions to and through communities of faith, especially for finding men

Below is a detailed breakdown of the budget and proposed activities by agency.

Preventing sexual violence and HIV risk in 9-14 year old girls and boys

Table 1: Budget for 9-14 year olds by Activity and Agency:

FBO Activity	Budget	Agency
Expand evidence-based primary prevention of sexual violence against children ages 9-14 and HIV targeting faith and traditional leaders and parents of 9-14 yrs using *SASA!* Faith, Coaching Boys Into Men, Faith Matters, and Families Matter programs in all the SNUs where we have OVC and DREAMS programs; provide FBOs with technical assistance to develop and implement child safeguarding policies	$525,000	USAID
Raise awareness for faith and traditional leaders about sexual violence and HIV risk faced by 9-14 year olds including production of full-length documentary	$150,000	USAID
Train FBO and traditional leadership on prevention of sexual violence using ImPower and CETA	$250,000	CDC
Engage "Basireletsi" Faith Champions program to raise awareness of child safeguarding policy development and implementation through faith and community structures	$100,000	CDC
Disseminate documentary through national screening tour and roadshow in churches and interfaith communities to promote prevention and response to sexual violence against children and build coalition of FBO engagement	$200,000	CDC
TOTAL	**$1,225,000**	

Unclassified

The past 2 years have seen the PEPFAR/B OVC program evolve and shift focus to the 9-14 year old both boys and girls, targeting them with primary prevention of sexual violence and HIV. The focus started during COP17 implementation in the two DREAMS SNUs where we are implementing both DREAMS and OVC via one implementing partner, PCI. The program has since been extended to non-DREAMS SNUs during COP18 implementation and this will continue in COP19. The program focusing on 9-14 year olds is comprehensive in that it addresses not only the adolescents, but extends to their families through Families Matter Program and gate-keepers of their communities using *SASA!*

In terms of adolescents themselves, these services specifically target the younger age groups of 9-14 (pre-adolescence stage) who are deemed to have not started engaging in risky behavior. The program equips them with the necessary skills to prevent sexual violence (either as perpetrators or victims), prevention acquisition of HIV for those that are HIV negative and prevent spreading of HIV for those already infected. Implementation is done through schools as the majority of the 9-14 year olds are in school. This therefore requires close coordination and collaboration with the relevant GoB ministry, in this case, Ministry of Basic Education (MoBE). Through OVC and DREAMS platforms, parents of 9-14 year olds are also being reached through parenting programs in order to help parents develop the necessary skills to engage in healthy relationships that promote honest and open conversations. In DREAMS SNUs for example, we are implementing the *Families Matter* Program (FMP) to reach the parents. In terms of their communities, engagement is done using *SASA!* to reach community gate keepers such as traditional leaders with focusing on community mobilization and norms change.

In COP19, PEPFAR/B programming for 9-14 year olds will have an additional layer of beneficiaries through reaching FBO leaders and their followers. The work will involve expanding evidence based primary prevention of sexual violence and HIV targeting faith and traditional leaders with *SASA!* faith. Since work will also expand to reach followed, some of the evidence based interventions to be used will include *No Means No (IMPOWER), Common Elements Treatment Approach (CETA) and Faith Matter (from Families Matters* Program). This work will be done in all the SNUs where we are implementing PEFPAR programming, and specifically leveraging the OVC and DREAMS platform where such work exists. The work with FBOs will also include providing FBOs with technical assistance to develop and implement child safe-guarding policies for their own organizations. This work will build on the experience that the current OVC IPs have in this area, having been trained by a USAID centrally funded program in 2017 to design child safe guarding policies for organizations working with children. Additionally, through the FBO funds, a full length documentary will be produced to be used to raise awareness for faith and traditional leaders about primary prevention of sexual violence and HIV faced by 9-14 year olds. This documentary will be disseminated through a national screening tour and roadshow in churches and inter-faith communities to promote prevention and response to sexual violence against children.

Engaging communities of faith to understand the epidemic, raise community awareness, and bring critical prevention and treatment interventions to and through communities of faith, especially for finding men:

Unclassified

Table 2: Budget for finding men by Activity and Agency:

FBO Activity	Budget	Agency
Support programming on basic HIV education and stigma reduction for FBO and traditional leadership and create a coalition between DHMTs and interfaith leaders to promote HIV services, especially to men	$250,000	CDC
Build capacity among local faith leaders and organizations, including church camps, to create demand for and implementation of self-testing	$200,000	CDC
Disseminate documentary through national screening tour and roadshow in faith communities to promote HIV case-finding and community support	$125,000	CDC
Engage champions in all faith communities through the "Basireletsi" Champions of Faith program to strengthen linkage and adherence and address ARV non-adherence associated with faith-healing	$100,000	CDC
Develop and/or adapt new messaging about HIV testing, linkage, and retention for widespread dissemination in churches and mosques, especially for finding men, including creation of full-length documentary	$150,000	USAID
Build capacity among local Christian faith leaders and organizations to create demand for and use of targeted distribution of HIV self-tests in faith communities by trusted leaders; conduct training program for faith leadership and the traditional healers community	$400,000	USAID
TOTAL	**$1,225,000**	

PEPFAR/B recognizes the faith community as a key partner in identifying specific populations and persons who do not routinely access health services such as men, youths and other PLHIV communities. To do that PEPFAR/B will reach into the faith based communities and churches to find these populations, offer them targeted testing services including self-testing, link them to treatment, support them to be retained in treatment and virally suppressed. PEPFAR/B will work with the GoB and existing faith-based partners, who are well established, and have extensive experience in providing facility and community based HIV interventions across the continuum to reach the faith based communities.

For intense and immediate engagement PEPFAR/B will produce a full length documentary that would explore the issues of faith healing involving both pastors and traditional healers. This tool will be disseminated nationwide to encourage health seeking behaviors especially amongst men who usually prefer to use traditional herbs before seeking medical attention. A systematic review of Integrated Patient Management System (IPMS) and Patient Information Management System (PIMS) reveals that there is a high number of people in Botswana who believe in traditional medicines and usually combine it with ART. Implementing partners will also develop an incentivized mechanism with traditional doctors to facilitate linkage to treatment. This is another best practice that has the potential to increase linkage to treatment. Traditional healers will be capacitated to administer HIV self-test kits and refer appropriately.

Other specific interventions that will be implemented in COP19 include:

Unclassified

- Utilizing expert clients found within communities of faith to champion linkage to treatment and other clinical services. Capacity building for expert clients will be done by the Botswana Christian Intervention Program (BOCAIP) and health facilities
- Convening men's forums and workshops targeting men in faith based communities to discuss barriers surrounding poor health seeking behavior among men, and come up with solutions to addressing these barriers. The discussions will entail barriers to accessing testing services, Linkage to Treatment, and retention on treatment. These forums will also be a platform for optimized demand creation for men to access testing services, collect self-test kits, benefit from Index testing services, and access available men friendly clinics and corners.
- Recruiting, engaging and training champions of faith who will be early adopters of innovative models for accessing services such as HIV self-tests (HIVST) and men's clinics to be influencers and educate congregants on the most up-to-date strategies for epidemic control. The faith champions will also conduct demand creation activities targeted to the faith communities, especially men and youth church platforms, to promote new testing modalities such as HIVST and PITC along with targeted distribution of HIV self-tests, and targeted case identification through other modalities as applicable. FBOs through Faith champions will promote treatment options available through government and non-governmental initiation sites, encourage same day initiation on treatment, adherence support, promotion of Differentiated Service Delivery models such as Multi Month Dispensing) of ARVs, community based ARV refills and distribution. The champions will emphasize the importance of retaining on treatment and being virally suppressed and Undetectable =Untransmittable (U=U) education.
- Programming on basic HIV education and stigma reduction and convening faith leaders to facilitate sharing solutions, the relationship between TB and HIV, promotion of TPT among those that are positive, promotion of EID services and linkage of the mother baby pairs for testing services. Faith leaders and champions will also promote a model of males adopting boys to mentor them towards HIV prevention, testing, treatment and viral suppression.

Unclassified

APPENDIX F – Acronym List

Abbreviation	Definition
ACHAP	African Comprehensive HIV/AIDS Partnership
A&E	Accident and Emergency
AGYW	Adolescent Girls and Young Women
AIDS	Acquired Immunodeficiency Syndrome
ALT	Agency Leads Team
ANC	Antenatal Care
AOR	Agreement Officer Representative
APC	Advancing Partnerships in Communities (FHI360)
APR	Annual Performance Review
ART	Anti-Retroviral Therapy
ARV	Anti-Retroviral Drugs
AYP	Adolescents and Young People
ASRH	Adolescent Sexual and Reproductive Health
BAIS	Botswana AIDS Impact Survey
BAIS - TB	Botswana AIDS Impact and Tuberculosis Prevalence Survey
BBSS	Behavioral and Biological Surveillance Survey
BCPP	Botswana Combination Prevention Program
BDF	Botswana Defense Force
BNTB	Botswana National Tuberculosis Program
BUMMHI	Botswana University of Maryland Medical Health Initiative
BUP	Botswana University of Pennsylvania
CBS	Case-Based Surveillance
CCM	Country Coordinating Mechanism
CDC	Center for Disease Control
CETA	Common Elements Treatment Approach
CHW	Community Health Worker
CM	Case Manager
CMS	Central Medical Stores
Co-Ag	Cooperative Agreement
CODB	Cost of Doing Business
COR	Contracting Officer Representative
COP	Country Operational Plan
CPT	Cotrimoxazole Preventative Therapy
CQI	Continuous Quality Improvement
CSO	Civil Society Organization
DHIS	District Health Information System
DHMT	District Health Management Teams
DoD	Department of Defense

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DOT	Directly Observed Therapy
DQA	Data Quality Assessment
DQI	Data Quality Improvement
DSD	Direct Service Delivery
DSD	Differentiated Service Delivery
DTBE	CDC/Division of Tuberculosis Elimination
DTG	Dolutegravir
DW	Data Warehouse
EA	Expenditure Analysis
EC	Expert Client
EFV	Efavirenz Sustiva ARV
EID	Early Infant Diagnosis
EMR	Electronic Medical Record
EPOA	Enhanced Peer Outreach Approach
EQA	External Quality Assurance
FAST	Funding Allocation to Strategy Tool
FBLO	Facility Based Linkage Officers
FBO	Faith-Based Organizations
FCTO	Facility Case Tracking Officer
FP	Family Planning
FSW	Female Sex Worker
FY	Fiscal Year
GBV	Gender-Based Violence
GDN	Government Data Network
GF	Global Fund
GFATM	Global Fund for AIDS, TB and Malaria
GHSC	Global Health Supply Chain Program
GIS	Geographical Information System
GNI	Gross National Income
GoB	Government of Botswana
HCA	Health Care Auxiliary / Health Care Assistant
HCD	Human Centered Design
HCW	Health Care Worker
HEA	Health Education Assistant
HEI	HIV Exposed Infant
HEW	Health Education Worker
HIS	Health Information Systems
HIV	Human Immunodeficiency Virus
HIVST	HIV Self Testing
HLF	Health Leadership Forum
HRH	Human Resources For Health
HTC	HIV Testing And Counseling

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HTS	HIV Testing Services
HWG	Health Working Group
ICPN	Index Client Partner Notification
ICPT	Index Client Partner Testing
ICS	Integrated Country Strategy
IDCC	Infectious Disease Control Centers
ICT	Information and Communications Technology
IEC	Information, Education and Communication
IP	Implementing Partner
IPBS	Integrated Planning and Budgeting System
IPMS	Integrated Patient Monitoring System
IPT	Isoniazid Preventive Therapy
IPV	Intimate partner violence
IQC	Internal Quality Control
IT	Information Technology
ITECH	International Training and Education Center for Health
KP	Key Populations
LCI	Local Capacity Initiative
LEEP	Loop Electrosurgical Excision Procedures
LIS	Laboratory Information System
LMIS	Logistics Management Information System
LMU	Logistics Management Unit
LTC	Linkage to Care
LTT	Linkage to Treatment
LTFU	Loss-To-Follow-Up
LPV/r	Lopinavir/Ritonavir ARV
M&E	Monitoring and Evaluation
MAT	Medication-Assisted Therapy
MCH	Maternal and Child Health
MFDP	Ministry of Finance and Development Planning
MMD	Multi-month Dispensing
MMS	Multi-Month Scripting
MNIGA	Ministry of Nationality, Immigration, and Gender Affairs
MoBE	Ministry of Basic Education
MoHW	Ministry of Health and Wellness
MoTE	Ministry of Tertiary Education
MPR	Minimum Program Requirements
MSM	Men Who Have Sex With Men
NACA	National AIDS Coordinating Agency
NAHPA	National AIDS & Health Promotion Agency (formerly called NACA)
NASA	National AIDS Spending Assessment
NCCPP	National Cervical Cancer Prevention Program
NCD	Non-communicable Disease

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NGO	Nongovernmental Organization
NIH	National Institutes of Health
NPD	Nurse Prescriber (and Dispenser)
NSF	National Strategic Framework
NVP	Nevirapine
OGAC	Office of the Global AIDS Coordinator
OI	Opportunistic Infection
OMRS	Open Medical Record Systems
OPD	Out-Patient Department
OU	Operating Unit
OVC	Orphans and Vulnerable Children
PACT	Peer Approach to Counselling Teens
PC	Peace Corps
PCI	Project Concern International
PCO	PEPFAR Coordination Office
PCT	PEPFAR Country Team
PCV	Peace Corps Volunteer
PEP	Post Exposure Prophylaxis
PEPFAR	President's Emergency Plan For AIDS Relief
PEPFAR/B	PEPFAR Botswana
PHDP	Positive Health, Dignity, and Prevention
PIMS	Patient Information Management System
PITC	Provider Initiated Testing and Counselling
PLHIV	People Living With HIV
PLL	Planning Level Letter
PMH	Princess Marina Hospital
PMT	PEPFAR Management Team
PMTCT	Prevention of Mother-to-Child HIV Transmission
PN	Peer Network
POART	PEPFAR Oversight and Accountability Results Team
POC	Point of Contact
PP	Priority Population
PPP	Public-Private Partnerships
PR	Principal Recipient
PrEP	Pre-Exposure Prophylaxis
PS	Permanent Secretary
PSM	Procurement and Supply Management
PT	Proficiency Testing
Q1	Quarter One
QI	Quality Improvement
RPM	Regional Planning Meeting
RTK	Rapid Test Kits
SCM	Supply Chain Management

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SCMS	Supply Chain Management System
SDS	Strategic Direction Summary
SI	Strategic Information
SID	Sustainability Index and Dashboard
SIMS	Site Improvement Monitoring System
SMS	Short Message System
SNU	Sub-National Unit
SOP	Standard Operating Procedures
SRE	Surveillance/Surveys, Evaluations and Operations Research
SRH	Sexual and Reproductive Health
STI	Sexually Transmitted Infection
SW	Social Worker
TA	Technical Assistance
TAF-ED	Tenofivir Alafenamide-Emtricitabine/Dolutegravir ARV
TB	Tuberculosis
TEE	Tenofovir/Emtricitabine/Efavirenz ARV
TLE	Efavirenz/Lamivudine/Tenofovir Disoproxil Fumarate ARV
TLD	Tenofovir/Lamivudine/Dolutegravir ARV
TPT	TB Preventative Therapy
TWC	Tebelopele Wellness Center
TWG	Technical Working Group
TX	Treatment
U=U	Undetectable =Untransmittable
UN	United Nations
UNAIDS	United Nations Programme on HIV/AIDS
USAID	United States Agency for International Development
USD	United States Dollars
USG	United States Government
VL	Viral Load
VMMC	Voluntary Medical Male Circumcision
WHO	World Health Organization
WLHIV	Women Living with HIV
YFC	Youth Friendly Clinic
YFS	Youth Friendly Service

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APPENDIX G – PEPFAR Botswana Partners and Stakeholders

A. Government of Botswana

- National AIDS and Health Promotion Agency (formerly National AIDS Coordinating Agency)
- Ministry of Health and Wellness
- Ministry of Local Government and Rural Development
- Ministry of Basic Education
- Ministry of Tertiary Education, Research, Science and Technology
- Ministry of Nationality, Immigration and Gender Affairs
- Ministry of Employment, Labor Productivity, and Skills Development
- Ministry of Youth Empowerment, Sports, and Cultural Development
- Ministry of Finance and Development Planning
- Botswana Defense Force

B. Implementing Partners

- African Comprehensive HIVAIDS Partnership (ACHAP)
- Botswana Harvard Partnership
- Botswana University of Maryland School of Medicine Health Initiative (BUMMHI)
- Botswana University of Pennsylvania Partnership (BUP)
- Catholic Relief Services
- Chemonics/Global Health Supply Chain
- Chemonics/Human Resources for Health 2030
- FHI 360/APC
- FHI 360/LINKAGES
- JHPIEGO
- Johns Hopkins University Center for Communications Programs
- KNCV Tuberculosis Foundation/Challenge TB
- Project Concern International (PCI)
- Results4Development
- Univ. of Washington International Training and Education Center for Health (ITECH)

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C. Local Implementing Partners

- Bakgatla Bolokang Matshelo
- Botswana Baylor Children's Centre of Clinical Excellence
- BOCAIP (Botswana Christian AIDS Intervention Program)
- Botswana GBV Prevention and Support Centre
- Botswana Institute of Clinical Laboratory Professionals
- Hope World Wide Botswana
- Humana People to People
- Kuru Family of Organizations
- Lesbians, Gays, and Bisexuals of Botswana (LeGaBiBo)
- Matsheng Community Development Association Trust
- Men for Health and Gender Justice
- Mothers Union
- Nkaikela Youth Group
- Silence Kills Support Group
- Sisonke Botswana
- Stepping Stones International
- Tebelopele Voluntary Testing and Counseling
- Viamo

D. Multilateral Organizations

- Delegation of the European Union
- Global Fund CCM
- SADC Secretariat
- IOM
- UNAIDS
- UNDP
- UNICEF
- UNFPA
- UN Women

E. Private Sector Organizations

- Aviwe Healthcare and Training Institute
- Botswana Business Coalition on HIV/AIDS
- Careena Centre for Health
- Debswana
- Indus Healthcare
- Premiere
- Associated Fund Administrators

F. Civil Society Organizations

- African Methodist Episcopal Services Trust
- African Union Youth Club Botswana
- Anglican Diocese of Botswana
- Bamalete Lutheran Hospital
- BAPR (Botswana Assn. for Psychosocial Rehabilitation)
- BAYOREC (Baikagisesha Youth Rehabilitation Centre)
- BOCONGO (Botswana Council of NGOs)
- BOFABONETHA (Botswana Faith-Based Network on HIV/AIDS)
- BOFWA (Botswana Family Welfare Assn.)
- Bomme Isago Organization
- Bona Naledi Society
- BONASO (Botswana Network of AIDS Service Organisations)
- BONELA (Botswana Network on Ethics, Law and HIV/AIDS)

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- BONEPWA+ (Botswana Network of People Living with HIV/AIDS)
- BORNUS (Botswana Retired Nurses Society)
- Botswana Council of Churches
- Botswana Council of Women
- Botswana Flying Mission
- Botswana HIV Clinicians Society
- Botswana Muslim Association
- Botswana Network for Mental Health
- Botswana Red Cross Society
- Botswana Scouts Association
- Botswana Society for the Deaf
- Botswana Student Network
- Botswana YALI Alumni Network
- CEYOHO (Center for Youth of Hope)
- Childhood Cancer Parents Assn. of Botswana
- Childline Botswana
- Cynthia Childcare Counseling Trust
- Ditshwanelo Centre for Human Rights
- Evangelical Fellowship of Botswana
- Family of Hope Services
- Friends of Diversity
- Gender Links
- Lenkokame Foundation
- Letsema Resource for Women in Politics
- Light and Courage Centre Trust
- Machaneng Achievers Association
- Marang Child Care Network Trust
- Men and Boys for Gender Equality
- Molao Matters
- NCONGO (Ngamiland Council of NGOs)
- Open Baptist Church
- Organization of African Instituted Churches
- Ouma Rammidi Foundation
- Pilot Mathambo Foundation
- Positive Moments Support Group
- Prison Fellowship International
- Rainbow Identity Association
- Sentebale
- Seventh Day Adventist Church
- Skill Share International Botswana
- Spiritual Assembly of Bahai in Botswana
- THC Foundation
- University of Botswana Women Against Rape (WAR)
- Young Love (Young 1ove)
- Youth for Christ Botswana

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